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TEENAGERS IN CRISIS: ISSUES AND PROGRAMS

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, D.C., ON OCTOBER 27, 1983

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TEENAGERS IN CRISIS: ISSUES AND PROGRAMS

THURSDAY, OCTOBER 27, 1983

HOUSE OF REPRESENTATIVES,
TASK FORCE ON CRISIS INTERVENTION,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, D.C.

The task force met, pursuant to call, at 9:45 a.m, in room 2261, Rayburn House Office Building, Hon. Lindy Boggs (chairman of the task force) presiding.

Members present: Representatives Boggs, Sikorski, Leland, Miller (ex officio), Fish, Johnson, Wolf, Marriott (ex officio), Levin, Wheat, and Coats.

Staff present: Alan J. Stone, staff director and counsel; Ann Rosewater, deputy staff director; Marcia Mabee, professional staff; George Elser, minority counsel; and Joan Godley, committee clerk.

Mrs. BOGGS. The hearing will come to order, please.

We welcome all of you and we are very, very pleased to see so many interested persons in the room. We are very proud to have the array of witnesses who are coming before us today.

The focus of today's hearings is "Teenagers in Crisis: Issues and Programs." Many of you have been reading in your local newspapers about the tragedy of teenage suicide. We hope this morning to better understand why young people, full of promise and on the brink of life, choose death.

We will hear from a courageous parent who will share her very recent experience with suicide. We will also hear about a suicide prevention center in Dallas, Tex., that reached out to her. We will hear from two researchers who have made important recent contributions to the field of adolescent suicide.

But while we hope to gain a better sense of what teenagers need when they are in the midst of the crisis of suicide, substance abuse, or a runaway episode, we will also learn from an expert with deep understanding of adolescence the disturbing fact that great numbers of teenagers in our Nation are growing up with little guidance from adults. Twenty-two percent of all children in the United States under the age of 18 live in a single-parent family, the vast majority of which are headed by women who must work. Sixty-six percent of all married women with children under 18 work, some because they choose to, but most others because their families need their financial contributions.

We do not know enough about how children in these families are supervised during or after school hours. It is a critical information gap. But we do know that in addition to severe cutbacks in crisis services in many communities, recent cuts in public support have

led to elimination of extracurricular programs in schools and reductions in library services, two widely available resources that can provide important developmental opportunities for young people.

We will hear firsthand from two children of single-parent families and from the directors of exemplary after-school programs they attend. We will learn from them what a community commitment can mean to a young person's development of self-esteem so essential to dealing successfully with life's crises.

Finally, we will also hear this morning from a very special young woman, Kim Fields, costar of the television series "Facts of Life," is able to join us this morning to tell us about the efforts she makes on behalf of young people across the Nation. She is a peer leader in the most important sense.

Let me conclude now so that we can hear from those individuals who are much more able than I am to tell you about these issues and concerns.

First, I am sure that some of the other members have opening statements.

Mr. Miller.

Chairman MILLER. I have no opening statement, Madam Chairman, I just want to commend you for holding these hearings. I think all of us that have raised children know the joys and the pains of adolescence. I think that this hearing is going to be very helpful for members of the committee as we continue to struggle with what is the proper role of the government, of the private sector, of our religious communities and others in trying to provide support for our teenagers who do confront some very, very serious problems during their most active years of life.

I think that we will find, as with your first hearing on crisis intervention, that this hearing will be very, very helpful to the members of the committee.

Mrs. BOGGS. Thank you very much, Mr. Chairman.

Mr. Leland.

Mr. LELAND. Thank you, Madam Chairperson, and members of the committee.

Today we will address the issues and programs affecting teenagers in crisis. I am sure if we take the time to remember our own adolescence and reflect upon it without bias, we might allow ourselves to recall the so-called growing pains that accompanied us during parts, if not throughout, our teenage years.

If I recall correctly, we were told by our elders that it was normal to feel awkward or out of place in an as-yet-undefined world. Yet, we cannot equate our own experiences at that time to the psychological repercussions of being a teenager in society today.

Without going into the diverse theories of adolescence put forth by such experts as psychologists, psychiatrists, sociologists, biochemists, and even anthropologists, I believe that we can no longer sit idly by trying to reason with the staggering statistics of our young people who try and succeed in taking their own lives, the increasing number of teenage pregnancies and the increasing number of runaways, to name but a few serious problems that our young people are experiencing today.

I commend you, Madam Chairperson, for assembling these distinguished panelists and I am encouraged by the attention given to the issue of teenage crisis in that I hope we can bring to light the great need for more funding in areas of critical importance, including research, on the taboo issue of suicide, as well as for programs that utilize after-school time.

Thank you very much, Madam Chairperson.

Mrs. BOGGS. Thank you, Mr. Leland.

Mr. Wheat.

Mr. WHEAT. Madam Chairperson, I have no formal statement, but let me commend you for holding this hearing today. As you may be aware, I have formed an advisory group in Kansas City to look into a number of matters that this committee is going to be examining throughout the next year. One of the first recommendations of the advisory group was that the Select Committee look at the question of teenage suicide. Teenage suicide is a growing problem, one that needs the attention of the Congress of the United States.

I would like to commend you for scheduling a hearing on this subject and for providing Members with an opportunity to begin close examination of this critically important problem.

Mrs. BOGGS. Thank you so much, Mr. Wheat. I would hope that each member of this committee would follow your lead in forming task forces or commissions within their own communities to carry out the work of the committee. I certainly commend you on such an action.

We are privileged today to have as our first two witnesses, Dr. Joan Lipsitz, who is the director of the Center for Early Adolescence at the University of North Carolina at Chapel Hill, and she will be joined by Kim Fields, who is the costar of the television series, "Facts of Life." Ms. Fields is accompanied by Brian Dyak, who is a great expert in this field as well.

We welcome you to the panel and we would be very happy to hear from you, Dr. Lipsitz.

STATEMENT OF JOAN LIPSITZ, DIRECTOR, CENTER FOR EARLY ADOLESCENCE, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Ms. LIPSITZ. Thank you, Chairperson Boggs, Congressman Miller, and other members of the committee.

My name is Joan Lipsitz. I am the director of the Center for Early Adolescence at the University of North Carolina at Chapel Hill and I appreciate being invited to share with you some observations and information this morning.

The title of my written testimony, which I am summarizing now, is "Making It the Hard Way: Adolescents in the 1980's."

Mrs. BOGGS. We will be happy to put your entire testimony in the record, Doctor.

Ms. LIPSITZ. Thank you.

I propose to begin by giving you an abbreviated summary of statistical trends concerning adolescents in America. I believe you will conclude, as I do, that the picture is a very mixed one.

We are beginning to see decreases in several indicators of stress and alienation among adolescents. For instance, the teenage birth rate has declined. Marihuana and alcohol abuse are declining. Juvenile crime is on the wane, including violent juvenile crime.

On the other hand, the school dropout rate remains stubbornly persistent, and the rate for Hispanics is especially appalling. Also, while almost 60 percent of teenagers had a job in 1980, as against 48 percent in 1960, the proportion of black male adolescents in the work force decreased from 44 percent in 1960 to 30 percent in 1980, and just the other day I saw the figures, from September 1983, that the black youth unemployment rate was 52 percent.

Likewise, the heartening decrease in antisocial and personally destructive behavior is no cause for complacency. The teenage birth rate has been declining, but the increase in out-of-wedlock births increased from 17 percent in 1960 to over 50 percent in 1978.

Despite the decrease in regular use of marijuana, the figures are not reassuring. Twenty-nine percent of high school seniors report having used marihuana in the past month. While juvenile crime figures are going down slightly, they are nonetheless disheartening.

The picture that I am left with as I review the statistics is of an age group making numerous vital decisions very early about life-enhancing and life-threatening issues. When I asked my then junior-high-age son not to go to a party where I suspected there would be drugs, he replied, "You allow me to go to school every day."

Fortunately the majority of these young people are making life-enhancing decisions. This is clearly not the case when we turn to adolescent suicide. Twenty percent of all people treated for depression are under 18 years of age. During the 1980's, teenagers have experienced the fastest growing suicide rate of any age group. Between 1960 and 1978, adolescent suicides among 15- to 19-year-olds doubled for all but black females.

Finally, one very troubling fact: Child abuse statistics refute several commonly held opinions about who is abused and who abuses. Incidents of reported abuse is distributed rather evenly across age, sex, and social class.

Younger children are thus not the most common victims, nor are the poor. As children become adolescents, the type, but not the incidence, of abuse changes. Abuse often begins when adolescents start asserting their independence from their parents.

Taken as a whole, the data do not present a picture of escalating woes or of a generation increasingly rejecting adult norms. I stress this point for several reasons.

First, adolescents are extremely vulnerable to external influences. If we portray them in the media and in legislative hearings as pathological, spaced-out, drunk and assaultive, we run the risk of encouraging greater numbers of young people unwittingly to fulfill our worst expectations.

The statistics on suicide bear eloquent testimony to the vulnerability of adolescents. The other statistics are less eloquent only because we have not learned to hear their signals of distress.

Second, statistical overviews rarely portray the strengths of an age group. I have not, for instance, been able to tell you the numbers of adolescents who volunteer in their communities or the

numbers who have excelled academically, artistically, athletically, or vocationally. These are important social indicators that simply are not available. I believe that fewer teenagers would be in crisis if they heard and read about their strengths and accomplishments.

Third, the incidence of most negative social indicators among adolescents is either horizontal or declining. If we have done something right, we need to continue, not to reduce or terminate our efforts. Because we succeed, for instance, in making large numbers of each generation of youngsters literate never has meant that we stopped teaching the next generation. It has meant that we try to identify what has failed or succeeded, with whom, and why, and to extend our efforts to more and more youngsters. The same should hold for our prevention and crisis intervention efforts.

Fourth, I want to highlight the downward trends so that we become so proud and possessive of them that we resist the impending reversals. It is wearisome to hear constantly that "there is no such thing as a free lunch" without also hearing that this observation is the equivalent of a double-edged sword.

Social costs will result from cost-cutting. Adolescents are expensive, as any parent can attest. There is no such thing as a free lunch. There are only choices in how we want to bear the expenses.

Statistical trends indicate areas of crisis, but they cannot tell us why adolescents are particularly prone to certain types of risk. A developmental profile helps explain this special vulnerability of adolescents. Adolescents' new sense of independence, of their personal destiny, their new ability to evaluate values, their self-consciousness about their emerging sexual maturity make them more fragile than we like to acknowledge.

Some adolescents integrate the often dramatic changes in their bodies with relative ease. For others, puberty is a disruptive experience. Feelings of loss of control and helplessness are not uncommon. Disturbances in self-esteem can be exacerbated when many changes occur at once. It is difficult for adolescents to cope with internal and external disruptions simultaneously.

They need the stabilizing influences of adults who attempt to keep disruption to a minimum, or to guide them through unavoidable dislocations.

Also, it is difficult for adolescents to feel normal. While the range of normal onset of puberty can be 6 years, every adolescent wants to come straight in on the 50-yard line, right down the middle of the field. One is always too tall, too short, too thin, too fat, too hairy, too clear-skinned, too early, too late. Problems of self-image are understandably rampant.

One of the tasks of adolescence is exploring one's personal uniqueness and also relatedness to other people. Identity is grounded in a world of others. All too many adolescents fail to receive consistent, positive, realistic reflections of themselves from the adults on whom they are deeply dependent.

Almost none receive the social coherence that would aid them in defining themselves because society's role expectations for adolescents are conflicted and contradictory. We don't know what we want them to be doing.

Adolescence is a time in life characterized by striving for achievement and competence. Shaky in self-esteem, beginning to

have a newfound sense of personal destiny and intensely self-conscious, adolescents are dependent on adults to afford them opportunities for achievement, competence, and social commitment. Because we give them almost no opportunity for acknowledged competence beyond academics and athletics, many adolescents are barred from adult recognition. In so doing, we abandon them to the peer group which, while more often than not supportive and generous, is equally shaky and needy.

I would like now to place these observations in the context of several dramatic changes taking place in adolescents' families and communities, changes that I believe signal our loss of social commitment to adolescence. I call this section "Adolescents on Their Own."

The number of children living in one-parent families has increased dramatically. By now the statistics are familiar. In 1982, 22 percent of all children under 18 were living in single-parent families. Within the context of one-parent families, the most rapid rate of increase occurred among children who were at least 10 years old. Among 10- to 17-year-olds, the increase was 50 percent.

These are also the children whose mother is most likely to be working full time. Thus, these children are least likely to be supervised at home in the after-school hours and out-of-school days. The problem of supervision is not solely a single-parent worry, however. Although the average labor force participation rate in 1980 for single-parent mothers with children ages 6 to 17 years old was 78 percent, the comparable figure for married mothers, while lower, was also high: 66 percent.

Nationwide data about child-care arrangements for school-age adolescents are not available, a dangerous gap in our information about this age group. We simply do not know how many of these young people lack contact with parents or other adults in their out-of-school hours. The Census Bureau, in effect, has lost the supervision issue.

We have glimmers now of data from local studies. We know from a very careful study of children ages 11 and 12 in Oakland, Calif., that no adult was at home to be with these sixth graders after school in 30 percent of one-parent and 23 percent of two-parent families.

The isolation of adolescents is not limited to urban areas. Montgomery County, Md., recently learned, in a report about to be released, that over one-third of the county's 9 to 11-year-olds and approximately three-quarters of 12 to 13-year-olds are in self-care or with a young sibling more than 10 hours a week.

The statistics on self-care cross all income levels and races in Montgomery County. I believe we are witnessing a trend toward the increasing solitude of middle-class youth. Suburbs are lonely places with one exception: The shopping mall, our new de facto community center for the youth of America.

Instead of hearing numerous calls for social attentiveness to this issue, we are throwing responsibility back onto young people to fend for themselves via self-help manuals, latchkey survival kits, and soon-to-appear self-help television spots for young viewers during Saturday morning cartoons. Is this the extent of the social effort we can muster?

It is intriguing that we must once again make the case for social attention to youth in the out-of-school hours. That case was made successfully in the early part of this century when urban areas were flooded with immigrant youngsters like my parents. In those days, the voices calling for community centers that would get young people off the streets, teach them basic skills and socialize them to mainstream American values belonged to the rich and powerful. We may today question some of their motives, but I doubt that many of us would take exception to their legacy: Playgrounds, parks, and community centers. Today, the voices recalling us to this former commitment are few and, ironically, no longer powerful.

I believe that concern about after-school care of adolescents, especially young adolescents, will increase as the number of working mothers continues to increase. The sheer numbers of unsupervised young teenagers will intensify public apprehension and lead to calls for greater social control of the young.

But opportunities for enriching experiences during the critical formative years of adolescence should not be tied solely to labor force and social control issues. Parents cannot and should not be their adolescents' sole source of information or companionship. Given what we know about adolescents' need to become increasingly independent from their parents, adults other than parents must be available to them. Otherwise, we abandon our youngsters to the enlarging youth ghettos of the after-school hours.

Public institutions have been and still could be well placed as providers of safe, supervised recreation, academic and cultural enrichment and counseling, but inflation and cutbacks in funding are taking their toll. For instance, given cuts in title XX funds, day-care programs have been forced to institute new fee schedules. Many parents have found they have to choose which of their children they can afford to send. They understandably choose to pay for their younger children and withdraw the older siblings who thus become so-called latchkey children. Libraries find that more and more young adolescents are using libraries as drop-in centers after school, much to their parents' comfort. But like municipal recreation departments, libraries have had to cut positions of people who specialize in youth work at precisely the time when more staff is needed to serve unsupervised teens.

One of the most dramatic cuts has been a change in eligibility in the child care food service program. In 1981, Public Law 97-35 reduced the age eligibility from 18 to 12, except for migrants and handicapped children. I cannot be sanguine about the short-sightedness of failing to enhance the nutrition of adolescents during a growth spurt second only to infancy in velocity.

Adolescents do not have to be a drain on the resources of their communities. They can, instead, be resources for their communities. Adolescents, when invited and encouraged, provide companionship to the elderly, take care of younger children in day-care centers, construct community playgrounds, paint and weatherproof houses, serve as museum guides, do food shopping for the housebound, shovel snow, clean parks. Their energy is proverbial.

The question is only how the energy will out, whether it will be against us, against themselves, or on behalf of us all. Gwendolyn

Brooks, in a poem called "Boy Breaking Glass," writes, "I shall create. If not a note, a hole. If not an overture, a desecration."

Sometimes, we must turn to poets to hear what we will not learn from our children.

Adolescence is not preparation for life; it is life. The 3 to 6 p.m. after-school issue challenges us to do for adolescents in the after-school hours what we must then do for them the rest of the day: To define meaningful social roles for youth as they mature into the healthy, responsible fulfilled adults we wish them to become.

Thank you.

[Prepared statement of Joan Lipsitz follows:]

PREPARED STATEMENT OF JOAN SCHEFF LIPSITZ, DIRECTOR OF THE CENTER FOR EARLY ADOLESCENCE AT THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Congresswoman Boggs, Congressman Miller, Congressman Marriott, and other members of the Committee. My name is Joan Scheff Lipsitz. I am the director of the Center for Early Adolescence at the University of North Carolina at Chapel Hill. I appreciate being invited to share some information and observations with you this morning as you consider "Teenagers in Crisis: Issues and Programs."

I propose to begin by throwing some numbers at you. Stated more elegantly, I want to give you you an abbreviated statistical portrait of adolescents in America. I believe you will conclude, as I do, that the picture is a very mixed one that indicates the need for a wide range of programs and policies.

In 1982 there were 22.3 million 12- to 17-year-olds in the United States. The number of teenagers has steadily declined since a high of over 24 million in the 1970s. Although the number will continue to decline through 1990, for which the projected figure is 19.5 million, it will still be considerably higher than the 18.2 million 12- to 17-years-olds in 1960.[1]

In addition to this decline in absolute numbers, the steady drop in the percentage of adolescents in relation to the total population indicates a shift toward a "more balanced age structure" [2] that, in and of itself, may account for some of the decreases we are beginning to see in several indicators of stress and alientation among adolescents. I would like to begin with an overview of statistics on education, employment, and marriage among teenagers, then review data on areas commonly interpreted as being indicators of a youth crisis, including pregnancy, venereal disease, substance abuse, smoking, crime, suicide, and runaways.

A STATISTICAL OVERVIEW

According to the National Assessment of Educational Progress, reading achievement scores have remained stable since 1970; the math achievement scores have remained stable for 9-year-olds and 17-year-olds from 1973 to 1982 and have risen for 13-year-olds.[3] The proportion of 12- to 16-year-olds who want to pursue a post-high-school education has not changed in the past decade; the percent of 12- to 16-year-olds who aspire to complete college has risen from 27 percent in 1966-70 to 42 percent in 1981.[4] In October 1980, 98.2 percent of 14- to 15-year-olds and 89 percent of 16- to 17-year-olds were enrolled in school.[5] The National Center on Education Statistics (N.C.E.S.) estimates that for every 100 pupils who were in the fifth grade in Fall 1972, 99 entered ninth grade in 1976, 89 entered eleventh grade in 1978, and 75 graduated from high school in 1980.[6] The percent of 17-year-olds who graduated from high school has remained remarkably horizontal: 70.8 percent in 1961, 76.3 percent in 1965; 72.5 percent in 1980 according to census data (or 73.6 percent according to N.C.E.S.).[7]

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[1] U.S. Department of Commerce, Bureau of the Census, "Marital Status and Living Arrangements," March 1980, Current Polulation Reports, Series P-20, 365, Table 4.

[2] Mark Testa and Fred Wulczyn, "The State of the Child", The Children's Policy Research Project, vol. I (Chicago Ill.: University of Chicago, 1980), p. 2.

[3] U.S. House of Representatives, Select Committee on Children, Youth, and Families, "U.S. Children and Their Families," 98th Cong., 1st sess. (Washington, D.C.: Author, 1983), pp. 24-25.

[4] Ibid. p. 42.

[5] "School Enrollment—Social and Economic Characteristics of Students: October 1980," Current Population Reports, May 1981, Series P-20, No. 362, table 6.

[6] National Center for Education Statistics, "School Retention Rates," Statistical Highlight (Washington, D.C.: GPO 1981, NCES 81-423).

[7] Select Committee on Children, Youth, and Families, p. 22.

One can make of statistics what one will. On the one hand, the dropout rate remains stubbornly persistent. In addition, these aggregated data mask important regional, socioeconomic, and racial differences. For instance, in school year 1980–81, 45.4 percent of students in Washington, D.C. who had previously been ninth graders did not graduate from high school; in Mississippi, the percent was 38.2, in Louisiana 36.6, in Florida 36.3, and in Georgia 35.7. On the other hand, in Iowa the percent was 15.2, in North Dakota, 15.1, and in Minnesota, 14.8 [8] The dropout rate among black and white 14- to 17-year olds appears to be the same, around 5.3 percent in October 1979; for 18- to 21-year-olds, however, the white dropout rate is 15.5 percent and the black dropout rate 25.5 percent.[9] Figures in Illinois from 1976 show extremely sharp racial differences that are all too familiar in other states. An estimated 13 percent of all Illinois 18- to 21-year-olds did not have a high school diploma; but close to one-third of the blacks and one-half of the Hispanics had not graduated from high school.[10]

Youth employment data are surprisingly mixed and more positive than anticipated. According to the Bureau of Labor Statistics, approximately 48 percent of teenagers had a job in 1960; in 1979, almost 60 percent worked. According to N.C.E.S., 63 percent of high school seniors and 52 percent of sophomores had a paying job in 1980.[11] Simmons Market Research Bureau in New York reports that in 1981, a 16-year-old male was three times as likely to work part-time than in 1960; a teenaged female was ten times more likely.[12]

Again, we can interpret these figures in various ways. On the one hand, today's youth are clearly not rejecting the work ethic, either because of economic necessity, because they embrace their parents values, or both. In fact, in 1980, 88 percent of high school seniors said that being successful in their line of work was very important to them, up 4 percent since 1972, and 84 percent said finding steady work was very important, up 6 percent.[13] This is not a picture of an unsocialized, irresponsible, devil-may-care group of adolescents. We can applaud ourselves, if we like, for having passed on an important social and personal value to our children.

On the other hand, at least one-third of young people will work at a fast-food restaurant when they are teenagers, in low-wage, tedious, dead-end, and sometimes dangerous jobs.[14] There are also indications that for some adolescents, numerous hours of work lead to lowered grades, greater occupational deviance, and other disturbing behavior.[15] And much more troubling are the statistics about black youth. The proportion of black teenagers in the work force has decreased from 45 percent in 1960 to 41 percent in 1979. For black males, the decrease is marked, from 44 percent to 30 percent, Hispanic teenagers appear to be faring better. In 1979, 50 percent of Hispanic teenagers held jobs.[16]

Yet another indication of the relative stability of the adolescent age group is the teenage marriage rate. Adolescents are not foreclosing their education and employment options through early marriage. In 1960, approximately 16 percent of teenaged girls were married; in 1969, the figure was 7.7 percent; in 1978, 6.9 percent. The parallel figures for boys were 8 percent, 2.1 percent, and 1.6 percent.[17]

As you will see, the statistics in very deeply troubling areas of adolescent behavior are also mixed. In all areas, we must bear in mind the aggregate data mask dramatic distress in subgroups of the population. In sum, taken as a whole, with the exception of adolescent suicide, there is a heartening decrease in anti-social and personally destructive behavior. And yet there is certainly no cause for complacency about the level of personal and societal pain that forms the reality behind these numbers. As Harold Richmond, Director of the Children's Policy Research Project in Illinois, says ". . . indicators on youth including teenage suicide, drug use, truan-

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[8] "Public High School for Graduates and Undergraduates," Education Week, 3, No. 3 (1983), 15.

[9] National Center of Education Statistics, "School Dropouts, by Age and Race, October 1979, "The Condition of Education (1981), table 1.13.

[10] Testa and Wulczyn, p. 100.

[11] Alvin Rosenbaum, "The Young People's Yellow Pages: A National Sourcebook for Youth" (New York: Putnam Publishing Group, 1983), p. 59.

[12] Ibid, p. 41.

[13] Select Committee on Children, Youth, and Families, p. 41.

[14] Rosenbaum, p. 60.

[15] See, for instance, Mary Ruggiero, Ellen Greenberger, Laurence D. Steinberg, "Occupational Deviance among Adolescent Workers," Youth and Society, 13, No. 4 (1982), 423–448; Laurence D. Steinberg, Ellen Greenberger, Laurie Garduque, and Sharon McAuliffe, "High School Students in the Labor Force; Some Costs and Benefits to Schooling and Learning," Educational Evaluation and Policy Analysis, 4 (1982), 363–372.

[16] Rosenbaum, p. 59.

[17] Ibid., p. 129.

cy and vandalism, juvenile crime, school dropouts and suspensions, and employment and unemployment suggest the sobering conclusion that a sizeable number of youth are alienated from themselves, from the law, and from those institutions designed to affect them most closely—family, school, and work."[18]

I mentioned a moment ago that the teenage marriage rate has declined. So has the teenage birthrate. Evidence indicates an increase in sexual activity among adolescents but a downward trend in adolescent childbearing. In 1960 the birthrate per 1,000 women ages 15 to 19 was 89.1. That number has steadily decreased. In 1978 it was 52.4.[19] But "while the teenage birthrate has been declining, the incidence of out-of-wedlock births among teenagers has been increasing. In 1978, over one-half of all births to teenagers were to women who were unmarried, compared to 17 percent in 1960." [20] In addition, while births to older teenagers are declining, births to younger teenagers increased, as of 1978. (They appear to have decreased subsequently. If so, this is the first good news we have had about teenage pregnancy in girls under 15 in two decades.) [21] The death rate among mothers from complications during pregnancy and childbirth is 13 percent greater for 15- to 19-year-olds than for women in their twenties. For teenagers under age 15, the death rate is 60 percent greater.[22] In general, teenagers are more likely to suffer from maternal and infant mortality and morbidity. Also, "so strong is the relationship between teenage pregnancy and financial dependency that researchers at the Urban Institute estimate that each year a woman delays her first birth, the probability that she will be in poverty at age 27 is reduced by about two percentage points." [23]

Of great interest to me are the following statistics. According to the Alan Guttmacher Institute, by age 13, one girl in 50 has had sexual intercourse at least once; by age 14, one in ten; by age 15, one in five, by age 16, one in three; by age 17, one in two; and by age 19, two in three.[24] One in every four cases of sexually transmitted diseases occurs in someone under age 19.[25] I think that despite the many differences of opinions and values we might hold, we all can agree that we would like girls to delay sexual activity, to avoid becoming pregnant, not to be early childbearers, and to delay marriage. We would like our children to be spared being infected by sexually transmitted diseases. The picture that I am left with as I review these statistics is of an age group making numerous vital decisions very early about life-enhancing and life-threatening issues. The same is true as we turn to other areas of risk-taking and decision-making.

For instance, a 1982 survey of 17,700 high school seniors, conducted by researchers at the University of Michigan on behalf of the National Institute on Drug Abuse, found that regular use of marijuana has dropped back to its 1975 level. Regular use of alcohol and smoking also seem to be in a steady decline now. Yet, the figures are not reassuring. Twenty-nine percent of seniors report having used marijauna in the past month (the figure was 37 percent in 1978 and 1979), and six percent say they use marijuana daily.[26]

I should point out that these figures are very slippery. Every study yields different numbers—but the same trends. The National Household Survey on Drug Abuse, which surveys American households every two or three years, reported that from 1979 to 1982, 12- to 17-year-olds showed a dramatic decline in current use of marijuana, from a survey high in 1979 of 16.7 percent to 11.1 percent. Lifetime use for 12- to 17-year-olds was down from 30.9 percent to 27.3 percent. Note that among 18- to 24-year-olds, the decline was smaller: from 35.4 percent to 27.5 percent.[27] The drug-abusing cohort is growing older and is evidently more resistant to influence.

Cigarette smoking also declined dramatically among high school seniors. Around 21 percent report daily use and 30 percent occasional use, down from a high of almost 29 percent daily use, and lower even than the 1975 figure of almost 27 percent.[28] These figures are more interesting when males and females are looked at

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[18] Harold Richman in Testa and Wulczyn, pp. xiii-xiv.
[19] Testa and Wulczyn, pp. 26–27.
[20] Ibid., p. 29.
[21] Ibid., p. 28.
[22] Ibid., p. 29.
[23] Ibid., p. 31.
[24] The Alan Guttmacher Institute, "Teenage Pregnancy: The Problem That Hasn't Gone Away" (New York: The Alan Guttmacher Institute, 1981), h.7.
[25] Rosenbaum, p. 152.
[26] "Drug Use Down—But Not Out--Among High School Seniors," Report on Education Research, 15, No. 4 (1983), 9.
[27] New York State Division for Youth, "Alternatives," No. 508 (June 1983), 1.
[28] "Drug Use Down," p. 9.

separately. Then we see that the figures are down for males, for instance from 31 percent in 1974 to 19.3 percent in 1979 among 17- to 18-year-olds smoking one or more cigarette a week; from 18.1 percent to 13.5 percent for 15- to 16-year-olds; and from 4.2 percent to 3.2 percent for 12- to 14-year-olds. Females ages 12 to 14 and 15 to 16 also show a decline in smoking; but smoking among females ages 17 to 18 has risen from 18.6 percent in 1968 to 25.9 percent in 1974 to 26.2 percent in 1979—remarkably higher than for males.[29]

I would like to point out that while percentages are going down, numbers are still high. What this means for the average 12-, 13-, 14-, or 15-year-old is that he or she is not shielded from the possibility of harm as some of us may have been when we were growing up. Rather, young adolescents are making crucial decisions about risk-taking behavior, sometimes daily. When I asked my then junior high-aged son not to go to a party where I suspected there would be drugs, he replied, "You allow me to go to school every day." Fortunately, the majority of these young people are making health-promoting decisions. We as well as they are indeed fortunate that so many young adolescents have the information and skills to protect themselves. I believe we need to give some credit to the adults—parents, professionals, and policymakers—whose prevention and intervention efforts in the past decade on behalf of these youngsters appear to be bearing fruit. And we need to renew our efforts on behalf of those hurting themselves and others.

Juvenile Crime is yet another case in point. First, it should be noted that adolescents are victims of crimes. Accidents, poisons, and violence are the leading causes of death for 15- to 24-year-olds.[30] (The incidence of homicide is five times greater for blacks than for whites.) The National Crime Survey of 1976, using data from 1972 and 1974 (the most recent), reported provocative statistics of teenage criminal victimization from a five-city study (Chicago, Detroit, Philadelphia, Los Angeles, and New York), suggesting a rise in victimization in major cities, especially among 12- to 15-year-olds.[31] N.I.E.'s Safe School Study reported in 1978 that seventh-grade boys in junior high schools are the most victimized of our students.[32]

Like so many other issues we wish data-gathering would clarify, juvenile crime statistics are spotty and sometimes contradictory. But again, as in other areas of youth alienation, juvenile crime is on the wane. The F.B.I.'s Uniform Crime Report for 1980 shows violent crime by minors decreased 2 percent from 1979 to 1980; property crime decreased more than 6 percent, and index crimes (violent crimes plus burglary, larceny, theft, and arson) dropped 6 percent. Between 1976 and 1980, all arrests for juveniles decreased 10 percent. Juvenile crime peaked in the 1970s and has been diminishing since.[33] Also, in 1978, the greatest percent (45.8) of juvenile offenses were against property. Status offenses constituted 23.7 percent of juvenile offenses, crimes against persons only 8.5 percent.[34]

While juvenile crime figures are going down slightly, they are nonetheless disheartening. In 1979 juveniles accounted for approximately 20 percent of all violent crime arrests and 44 percent of all serious property crime arrests.[35] Almost 65 percent of juvenile offenders are 15- to 17-year-olds; 25 percent are only 12- to 14-year-olds.[36]

When we move from the area of actual arrests to self-report studies we get a different picture. In an effort to reduce delinquency and increase positive youth involvement, Stratford, Conn. conducted a survey of young people in grades 7–12 in the spring of 1980. The investigators found, to their amazement (but consonant with other self-report studies), that more than 90 percent of the respondents reported having been involved in at least one form of delinquent activity. Grade level turned out to be an important correlate in the findings. With the exception of drug and alcohol use and distribution, all types of delinquency were most prevalent among eighth and ninth graders, then leveled off or decreased from tenth through twelfth grades.[37] Interestingly, peer pressure and alienation variables accounted for no

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[29] Select Committee on Children, Youth, and Families, p. 39.
[30] Ibid., p. 32.
[31] Testa and Wulczyn, p. 72.
[32] National Institute of Education, "Violent Schools—Safe Schools: The Safe School Study Report to Congress" (Washington, D.C.: GPO, 1978).
[33] "Juvenile Crime—Don't Bother Me With the Facts," Looking Glass, 5, No. 7 (1981), 2.
[34] National Center for Juvenile Justice, "Delinquency 1978: United States Estimates of Cases Processed by Courts with Juvenile Jurisdiction" (Washington, D.C.: GPO, 1981), Table 2.5.
[35] "Serious Juvenile Crime: How Prevalent?" Youth Alternatives, 8, No. 8 (1981), 5.
[36] National Center for Juvenile Justice, Table 3.3.
[37] Robert M. Francis and Grant Walker, "Adolescents: Segregated and Subordinated," New Designs for Youth Development, 2, No. 3 (1981), 10.

more than 35 percent of the delinquent acts, and these correlations were especially weak for eighth and ninth graders. The investigators thus report on what they call "free floating delinquency" that is seemingly "quasinormal," to use their term. They conclude that such delinquency will not be "counseled out" of youngsters, rather, structural changes in community organizations, including large increases in youth participation, are indicated.[38]

While we have scattered statistics, mental health figures are close to impossible to compile with accuracy, precision of definition, and age comparability. The Children's Defense Fund reports that two out of three seriously disturbed children and adolescents do not receive any services. Among the groups of troubled children least likely to receive appropriate and timely mental health care are "disturbed adolescents, especially those with serious or multiple problems and those who have been in hospital or may face hospital placement." [39] Twenty percent of all people treated for depression are under 18 years of age.[40] The President's Commission on Mental Health (1978) estimates that by age 18, 16 percent of the population will have needed mental health services.[41] Figures for 3- to 15-year-olds are estimated to be anywhere from 5 to 15 percent.[42]

We do know that during the 1980s, teenagers have experienced the fastest growing suicide rate of any age group.[43] Between 1960 and 1978 adolescent suicides among 15- to 19-year-olds doubled for all but black females.[44] The incidence of adolescent suicide is now two times greater for whites than blacks, three to four times greater for boys than girls.[45]

Sometimes, adolescents run away from home rather than from life. According to the National Network of Runaway and Youth Services, more than two million young prople run away annually. The typical runaway is a 15- to 17-year-old girl or boy. Seven in 10 return home and are reunited. Opinion Research Corporation says that more than half run less than 10 miles from home.[46]

Some are running from abuse. Child abuse statistics refute several commonly held opinions about who is abused and who abuses. Incidence of reported abuse is distributed rather evenly across age and sex. Younger children are thus not the most common victims. As children become adolescents, the type but not the incidence of abuse changes. While incidents of beatings, severe neglect, multiple injuries, and death decline as children grow bigger and stronger, sexual abuse rises, especially for girls.[47] Nor is abuse restricted to one social class. For instance, North Shore University Hospital's Family Crisis Treatment Center in Nassau County, N.Y., studied 87 suburban households in such townships as Great Neck, Manhasset, and Glen Cove. Adolescents aged 13 to 18 were abused twice as often as younger children. Abuse often began when adolescents started asserting their independence from their parents. "We are seeing families that are intact and affluent," says Dr. Sandra J. Kaplan, Chief of the Division of Child and Adolescent Psychiatry and head of the Center.[48]

OBSERVATIONS ABOUT THE STATISTICAL OVERVIEW

I believe you will agree with me that the statistics available, for all their inconsistencies, contradictions and inadequacies, must give us pause. When data are disaggregated, there are persistent and in some cases deepening areas of distress. Thus, perhaps the temperate tone of this statistical overview comes as a surprise to you and requires explanation. Taken as a whole, the data do not present a picture of escalating woes or of a generation increasingly rejecting adult norms. I stress this point for several reasons. First, adolescents are extremely vulnerable to external influences. If we portray them in the media and in legislative hearings as pathological, spaced-out, drunk, and assaultive, we run the risk of alienating greater num-

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[38] Ibid.

[39] Jane Knitzer, "Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services" (Washington, D.C.: Children's Defense Fund, 1982), p. x.

[40] Rosenbaum, p. 167.

[41] President's Commission on Mental Health, "Report of the Task Force Panel on Prevention," Vol. 4 (Washington, D.C.: GPO, 1978) pp. 1822-1863.

[42] Testa and Wulczyn, p. 58.

[43] Ibid.

[44] Select Committee on Children, Youth, and Families, p. 40.

[45] Testa and Wulczyn, p. 76.

[46] Rosenbaum, p. 261.

[47] Testa and Wulczyn, p. 67.

[48] "Child Abuse in Suburbia Refutes some Common Notions," N.Y. State Division for Youth, Alternatives, No. 461 (March 1983), 1.

bers of young people and of encouraging them unwittingly to fulfill our worst expectations. The statistics on suicide bear eloquent testimony to the vulnerability of adolescents. The other statistics are less eloquent only because we have not learned to hear their signals of distress.

Second, statistical overviews rarely portray the strengths of an age group. I have not, for instance, been able to tell you the numbers of adolescents who volunteer in their communities, or the numbers who have excelled academically, artistically, athletically, or vocationally. These are important social indicators that simply are not available. It comes as a surprise to us to hear in youth polls that close to 90 percent of adolescents say they respect their parents as people. I guarantee you that you will never read this as a headline in your local newspaper. I believe that fewer teenagers would be in crisis if they heard and read about their strengths and accomplishments. So, I have tried to be as temperate as possible, pointing out, for instance, not only how many young people take drugs, but also how many increasingly refrain; not only how many drop out of school, but also how many attend.

Third, I have stressed statistics of victimization, because, while adolescents are all too often victimizers, they are also victims. Our failure to recognize this is nowhere more evident than in the area of child abuse. We are persistent in our unwillingness to recognize the vulnerability of teenagers.

Fourth, the incidence of most negative social indicators among adolescents is either horizontal or declining. We cannot take all the credit for having caused this turn away from the unrelentingly escalating figures of the 1970s. When the size of the youth cohort decreases, so do the alarming statistics. On the other hand, this is a good time to step back and take credit that is due. If we have done something right, we need to continue, not to reduce or terminate our efforts. Because we succeed in making large numbers of each generation of youngsters literate never has meant that we stop teaching the next generation. It has meant that we try to identify what has failed or succeeded, with whom, and why, and to extend our efforts to more and more youngsters. The same should hold for our prevention and crisis intervention efforts.

Fifth, I want to highlight the downward trends so that we become so proud and possessive of them that we resist the impending reversals. A study published in late 1982 by the National Committee for the Prevention of Child Abuse informs us that despite the fact that 39 states reported higher rates of abuse, 32 states cut their child abuse and neglect budgets last year.[49] Because this is not an isolated phenomena and may be a sample of what lies ahead, I would like to call to your attention a brilliant study by Arden Miller and his colleagues, who compared the health status and health risks of children in the 1974–75 recession, when unemployment rates rivaled those of 1981–82, with the health status and health risks of children during the current recession. Their study, prepared for the United Nations Children's Fund, found that most measures of health status and health risk for children (e.g., infant mortality rate, low birth weight, child abuse and neglect, crimes and death associated with violence, hunger and nutrition, showed steady improvements throughout the 1970s, despite adverse economic trends. "Throughout the 1970s the exercise of public responsibility for financing and providing essential services and supports held constant or improved. Increase in health benefits was especially striking during 1974–75 recession," thus cushioning the adversities of the recession. On the other hand, "the health status and risks for children since 1981 appear to be adversely affected. . . The adverse effects on children's health since 1981 must be attributed to a combination of circumstances that include serious recession, increased poverty rates for households with children, and diminished health benefits and social support services. Earlier trends confirm that the public health and social programs were in fact working and that their withdrawal in the face of deepening economic recession subjected children to preventable risks to their health and well-being . . ." The study concludes that "when either local or widespread economic reversals are anticipated . . . health services and social supports for children need to be expanded rather than contracted."[50]

I am suggesting, then, that we cannot count on the continuing downward trends I have summarized in this review. Miller's study is the most current we have. It is careful in research, design, and statistical analysis. While, for the most part, it does

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[49] Ann Dorough, "Committee Debates Abuse Law Renewal," (SPS) News Report, Youth Policy Institute, Mar. 28, 1983, p. 10–A.

[50] C. Arden Miller, M.D., Elizabeth Coulter, Lisbeth B. Schorr, and Edward Brooks, "The World Economic Crisis and the Children: United States Case Study," Prepared for the United Nations Children's Fund, June 19, 1983, draft.

not address some of the indicators directly pertinent to adolescents, it must serve as a warning. The trends bear very careful watching.

It is wearisome to hear constantly that "there is no such thing as a free lunch" without also hearing that this observation is the equivalent of a double-edged sword. Social costs will result from cost-cutting. Adolescents are expensive, as any parent can attest. There is no such thing as a free lunch. There are only choices in how we want to bear the expenses.

A DEVELOPMENTAL PROFILE

A statistical profile indicates areas of crisis, but it cannot tell us why adolescents are particularly prone to certain types of risk. A developmental profile helps explain the special vulnerability of adolescence.

Biologically, adolescence consists of the years between the onset of puberty and the completion of bone growth. Puberty begins when the gonads secrete hormones in sufficient amount to cause accelerated growth and the appearance of secondary sex characteristics. Some adolescents integrate the often dramatic changes in their bodies with relative ease. For others, puberty is a disruptive experience.[51] Feelings of loss of control and helplessness are not uncommon. Disturbances in self-esteem can be exacerbated when many changes occur at once, for instance, the onset of menstruation, a geographic move, and changing schools.[52] It is difficult for adolescents to cope with internal and external disruption simultaneously.

The onset of various marker events of puberty, like the adolescent growth spurt, the appearance of secondary sex characteristics, and menarche/ejaculation, are so variable that it is difficult for adolescents to feel "average"—i.e., normal. While the range of normal onset can be six years, every adolescent wants to come straight in on the 50 yard line, right down the middle of the field. One is always too tall, too short, too thin, too fat, too hairy, too-clear-skinned, too early, too late. Problems of self image are understandably rampant.

The biological changes of puberty are universal. Beyond biology, adolescence is culturally determined and defined. American adolescents do not grow up in a vacuum, nor, in a certain sense, do they grow up in America. That is, they grow up in families, neighborhoods, communities, and regions. They also grow up in historical and economic eras. Thus, the psychosocial tasks of adolescence vary in their impact and meaning. For instance, becoming an adolescent during the Depression had a different meaning from growing up during the expanding economy of the 1950s, which was different from growing up in the present time of shriveling employment opportunities and inflation. Likewise, growing up black, poor, and hungry is not the same as growing up black, middle-class, and in designer jeans, nor is that the same as growing up Hispanic in the barrio, white in Appalachia, Asiatic in large cities, or white in suburbia. We can no more accurately talk about "adolescence" that we can about "mid-life" in this vastly heterogeneous country. At the same time, a developmental perspective sheds light on common themes in adolescence and why they lead to problems or crises.

If the tasks of adolescence were isolated phenomena rather than part of a continuum, they would be less crucial. Adolescence is a pivotal time in life; events in adolescence are in large measure determined by what has happened before and determine much of what follow.[53]

One of the tasks of adolescence is exploring one's personal uniqueness and relatedness to other human beings. A paradox of adolescence is that one achieves this sense of individuality only when one sees oneself in terms of a larger social context. Identity is grounded in a world of others.[54] Thus, adolescents are utterly dependent on others to reflect to them a positive, realistic image of themselves that they can integrate into their own inner image. They are also dependent on society to have a coherent set of purposes and expectations for them with which and against which

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[51] See, for example, Anne C. Petersen and Brandon Taylor, "The Biological Approach to Adolescence: Biological Change and Psychological Adaptation," in Handbook of Adolescent Development, ed. Joseph Adelson (New York: Wiley, 1980) pp. 117-55; Jill Rierdan and Elissa Koff, "The Psychological Impact of Menarche: Integrative Versus Disruptive Changes," Journal of Youth and Adolescence, 9, No. 1 (1980), 49-58.

[52] Roberta G. Simmons, Dale A. Blyth, Edward F. VanCleave, and Diane Mitsch Bush, "Entry into Early Adolescence: The Impact of School Structure, Puberty, and Early Dating on Self-Esteem," American Sociological Review, 44 (1979), 948-967.

[53] Erik Erikson, "Identity: Youth and Crisis" (New York: W.W. Norton, 1968), p. 23.

[54] Joan Scheff Lipsitz, "The Age Group," Toward Adolescence: The Middle School Years, Seventy-ninth Yearbook of the National Society for the Study of Education, Part I (Chicago: University of Chicago Press, 1980), pp. 7-31.

they can define themselves. All too many adolescents fail to receive consistent, positive, realistic reflections of themselves from the adults on whom they are deeply dependent. Almost none receive the social coherence that would aid them in defining themselves, because society's role expectations for adolescents are conflicted and contradictory.

Also crucial to adolescent development is the gradual process of separation from parental authority and the strengthening of personal autonomy. The key word here is "gradual," since separation is a lengthy process, not an event. Those youngsters for whom separation becomes an event (for instance, through the death of a parent, divorce that denies contact with a non-custodial parent, running away, and other traumas), are at considerable risk of becoming one of the dreadful statistics we are discussing today.

A critical task of adolescence is breaking through a characteristic form of egocentrism that David Elkind calls the "personal fable." This is a story the adolescent tells himself or herself and believes to be true: that he or she is unique, immune, even immortal.[55] This tendency to overdifferentiate the self from others poses an extraordinary but usually unacknowledged challenge to people concerned with prevention. Many adolescents, especially young adolescents, are locked into their "personal fable" and therefore feel that "it can't happen to me"—I can't get pregnant; I can't crash in this car; I can't get hooked on drugs. Prevention programs usually appeal to people's sense of vulnerability, to their being able to say, "It can happen to me. I am not unique." For members of an age group unable to make this cognitive leap from immunity to vulnerability, the messages of standard prevention programs are irrelevant. This is one reason that a developmental approach to services for adolescents is required, if we are to be more successful. Adolescents are not being perverse by feeling immune. They are being normal. The combination of this sense of immunity with adolescents' need to take risks to be adventuresome and spontaneous is one aspect of adolescent development that makes them so vulnerable to danger. As adolescents grow cognitively and are able to think abstractly and hypothetically, they are also able to break through this characteristic form of egocentrism.

Adolescence is a time in life characterized by striving for achievement and competence. This view of adolescence is so radically different from social stereotypes that it bears underscoring. Konopka talks about adolescence as an "age of commitment," a move into "true interdependence." Commitment includes a search for one's identity but also "points toward the emotional, intellectual, and sometimes physical reach for other people as well as ideas, ideologies, causes, work choices." According to Konopka, to acknowledge adolescence as an age of commitment is to elevate it from a stage to be "endured and passed through as rapidly as possible to a stage of earnest and significant human development."[56] Adolescents, shaky in self-esteem, beginning to have a new-found sense of personal destiny, and intensely self-conscious, are dependent on adults to afford them opportunities for achievement, competence, and commitment. Their budding sense of self reaches not only inward but also outward to friends, and beyond friends to the larger social order they are beginning to discover and explore. Because we give adolescents almost no opportunities for acknowledged competence beyond academics and athletics, and because we fail to invite the contributions they are ready to make to their communities, many adolescents are barred from adult recognition. In so doing, we abandon them to the peer group which, while more often than not supportive and generous, is equally shaky and needy.

While, as I said before, it is impossible to obtain reliable mental health statistics, the consistent theme of low self-esteem that pervades the literature on substance abuse, teenage pregnancy, dropouts, truancy, juvenile crime, and suicide is striking. I have never seen or read about a successful crisis intervention or prevention program for adolescents that did not address the issue of low self-esteem, directly or indirectly. It is the Achilles heel of adolescent development and the linchpin of successful programs.

ADOLESCENTS ON THEIR OWN

I have presented statistics about the status of adolescents and have made several observations about the tasks of adolescent development that lead to the special vul-

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[55] David Elkind, "Egocentrism in Adolescence," Child Development, 38 (1967), 1025–34.

[56] Gisela Konopka, "Requirements for Healthy Development of Adolescent Youth," Adolescence, 8 (1973), 11–12.

nerability of the age group. I would like now to place these observations in the context of several dramatic changes taking place in adolescents' families.

Because of the falling birth rate, the number of children in the United States declined in the 1970's; at the same time, the number living in one-parent families increased. By now, the statistics have become familiar. In 1982, 22 percent of all children under 18, or 14 million children, were living in single-parent families.[57] Data from the 1981 nationwide Census Bureau sampling indicates that the number of one-parent families headed by unwed women rose 356 percent, up from 234,000 to more than one million, from 1970 to 1980; the number of families headed by divorced women rose 181 percent, from 956,000 to 2.7 million.[58] Within the context of one-parent families, as Glick points out, the most rapid rate of increase occurred among children who were at least 10 years old. Among prenursery-age children (under 3), the percent rose 36 percent; among 10- to 17-year-olds, the increase was 50 percent.[59]

While the median family income in 1978 for mother-and-children-only families with all children under school age was $4500, the figure almost doubled ($8700) for mother-and-children-only families with all children of school age. This increase may be explained by the mother's longer average work experience, and it is definitely explained by her longer working hours.[60]

We do not know the consequences for adolescents of growing up in single-parent families. Research findings are contradictory. Given current estimates that by 1990 approximately three-quarters of all black children and one-third of all white children will spend some time in a single-parent family,[61] our need for greater clarification about this issue is urgent.

My purpose in reviewing these statistics is certainly not to add to the burdens of single parents or their children. It is, rather, to highlight Glick's findings that the greatest increase in single-parent families has occurred for children who are ten years old and older. These are also the children whose mother is most likely to be working full time. Thus, these are the children least likely to be supervised at home in the after-school hours and out-of-school days. Again, the problem of supervision is not solely a single-parent worry. From 1980 to 1981, 7 out of every 10 net additions to the labor force were female (1.2 million). Many of these women are married. In 1981, there were 25 percent more dual-earner, married couple families than in 1971.[62] Although the average labor force participation rate in 1980 for single-parent mothers with children ages 6 to 17 years was 78 percent, the comparable figure for married mothers, while lower, was also high: 66 percent.[63]

Nationwide data about child-care arrangements for school-age adolescents are not available, a dangerous gap in our information about this age group. We simply do not know how many of these young people lack contact with parents or other adults in their out-of-school hours. We do not know how safe they are or how well supervised. October 1974 census data indicated that 17.7 percent of 7- to 13-year-olds whose mothers were employed full time took care of themselves.[64] I believe we can safely assume that if we lopped off the younger children in these aggregated data, the percent of unsupervised older children would rise considerably. If we had current data, we might find that the figure for those children who are not supervised had soared, along with the burgeoning rate of single-parent families, single mothers in the labor force, dual-earner families, and adolescents in single-parent families. But we do not have current data on how well supervised our school-age children are in their out-of-school hours. In fact, we do not even have data comparable to the October 1974 data. The Census Bureau, in effect, has "lost" the supervision issue. The question about unattended children age 7 to 13 has not been updated for lack of funding, according to Martin O'Connell, Chief of the Fertility Statistic Branch of the Census Bureau.[65] The Committee's statistical report, U.S. Children and Their Fami-

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[57] Select Committee on Children, Youth, and Families, p. 8.

[58] "Homes Headed by Unwed Mothers Up 356 Percent," The Washington Post, 18 June 1982, p. A8.

[59] Paul C. Glick, "Children from One-Parent Families: Recent Data and Projections," Paper presented at the Special Institute on Critical Issues in Education, American University, Washington, D.C., 22 June 1981, p. 10.

[60] Ibid., p. 17.

[61] Testa and Wulczyn, pp. 17–18.

[62] U.S. Department of Labor, Bureau of Labor Statistics "Employment in Perspective: Working Women," 1981 Annual Summary, Report 663.

[63] Glick, p. 16.

[64] "Daytime Care of Children: October 1974 and February 1975," Current Population Reports, October 1976, Series P–20, No. 298, Table 5.

[65] Telephone conversation with Martin O'Connell, Chief, Fertility Statistic Branch, Census Bureau Oct. 13, 1983.

lies, presents no table on child care arrangements for school-age children in general, much less for adolescents, nor could you have obtained the data to compile one.

We have glimmers now of data from local studies. We know from a very careful study of children ages 11 and 12 in Oakland, California, conducted by Elliott Medrich and his colleagues, that of the 764 sixth graders interviewed, no adult was at home to be with the child after school in 30 percent of one-parent and 23 percent of two-parent families.[66] Fifty-one percent of these sixth graders said they often feel bored and do not know what to do after school. 82 percent said they watch television because they have nothing else to do. 81 percent would like to spend more time doing things with their parents.[67]

The isolation of adolescents is not limited to urban areas, where large percentages of young people never go outside their neighborhood on their own. Suburban and rural adolescents are also trapped, lacking public transportation or any place to go. Montgomery County, Maryland recently contracted with Applied Management Sciences to study the county's child care needs and resources. The report has not yet been released, but data indicate that over one-third of the county's 9- to 11-year-olds and approximately three-quarters of 12- to 13-year-olds are in self-care or with a young sibling more than 10 hours a week. The statistics on self-care cross all income levels and races, although those parents with the highest education and occupation levels are more likely to leave their children in self/sibling care than are parents with lower education and occupation levels. I believe we are witnessing a trend toward the increasing solitude of middle-class youth.[68] In fact, the isolation of separate residential developments can make libraries, school buildings, churches, synagogues, and recreation centers more out of reach for suburban than for urban adolescents who have access to public transportation. Suburbs are lonely places, with one exception: the shopping mall, our new de facto community center for the youth of America.

If a 14- or 15-year-old becomes a delinquent in the after-school hours, he or she will be attended to rather swiftly, if not rather well. But we are not likely to respond to the teenager who hangs around the house, neighborhood, or shopping mall, aimlessly seeking ways to kill time. Social attention follows obvious injury, especially where adolescents are concerned. The after-school hours, the time period that spawns what we at the Center for Early Adolescence call the 3:00 to 6:00 P.M. issue, illustrate our society's failure to follow through. Though we say we are committed to establishing a society that cares about all our children's development—adolescents as well as younger children—as individuals, as members of families, and as members of communities, we are not doing so.

It is intriguing that we must once again make the case for social attention to youth in the out-of-school hours. That case was made successfully in the early part of this century, when urban areas were flooded with immigrant youngsters. Then, the voices calling for community services were the conservatives, attempting to socialize the alien masses. The arguments of that period are refreshingly outspoken and to-the-point. For instance, Howard S. Braucher, a leader of the playground movement, wrote in 1916 that "the expenditure of tax funds for community centers [including playgrounds and vacation schools] is the best form of insurance against assassination and social revolution." [69] In those days, the voices calling for community centers that would get young people off the streets, teach them basic skills, and socialize them to mainstream American values belonged to the rich and powerful. We may today question some of their motives, but I doubt that many of us would take exception to their legacy: playgrounds, parks, and community centers. Today, the voices recalling us to a former commitment are few and, ironically, no longer considered conservative. As Medrich and his colleagues found in their study of children's lives out of school, "There is mounting evidence that fiscal pressures on municipalites are resulting in declining commitments to child-oriented out-of-school services and facilities. The implications of this trend demand attention for these services are important to children. . . We believe that cutbacks in services directed at them will mean that young people are bearing an unusually large share of the adverse consequences of the taxpayers' revolt. These basic services and facilities rep-

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[66] Elliott A. Medrich, Judith A. Roizen, Victor Rubin, and Stuart Buckley, The Serious Business of Growing Up: A Study of Children's Lives Outside School (Berkeley: University of California Press, 1982).

[67] Ibid.

[68] Telephone conversation with Millie Grant, Early Childhood Coordinator, Montgomery County Department of Family Resources, Oct. 18, 1983.

[69] Cited in Cary Goodman, "Choosing Sides: Playground and Street Life on the Lower East Side" (New York: Schocken Books, 1979), p. 61.

resent an important contribution to the quality of children's out-of-school lives. We view current developments with dismay, for we see little evidence that public authorities or adults generally are willing to confront this deteriorating situation." [70]

Instead of hearing numerous such calls for social attentiveness, we are throwing the responsibility back onto young people to fend for themselves, via self-help manuals, latchkey survival kits, and soon-to-appear self-help television spots for young viewers during Saturday morning cartoons. And we are reinforcing the isolation of youngsters with articles like one on "How to Make Your Kids Street Smart" in Family Circle, which advises parents, "Don't let kids go to school early or stay late, except when they're taking part in supervised activities. Schoolyards and playgrounds are notorious hangouts for both child molesters and marauding teenagers." [71] I do not dispute the need for booklets that teach youngsters on their own how to avoid setting the apartment on fire when they fix a snack for themselves or their younger siblings, nor do I dispute the need for articles that tell parents that formerly supervised areas are no longer safe. But is this the best we can do? Is this the extent of the social effort we can muster?

Several weeks ago when a researcher for the newly syndicated consumer-oriented television show, "Taking Advantage," attempted to ascertain where parents of young adolescents could find out about after-school services in their community, she learned what for her was a stunning lesson: nowhere. This television show would gladly have referred parents to an 800 number or a series of regional information networks had there been any. There are none.

Members of the Committee, what would you say are the greatest stabilizing influences in the lives of children? I am sure that in your list, which would have to include adequate food, housing, schooling, and health care, you would also include adults. I find it shocking that we must remind ourselves of this fact: adults are essential to the healthy development of adolescents. And what is your definition of "neglect"? Most of us shy away from defining "neglect." Guidelines of Tennessee's Department of Human Services define neglect as leaving a child under 9 unsupervised for any length of time, leaving 10- to 12-year-olds unsupervised for more than four hours, and leaving a child under 12 responsible for younger siblings for more than two hours. I think we can all imagine how many parents in Tennessee are neglected, under these guidelines. Our prisons would be filled with many of us in this room, and foster homes would be filled with our children, were most states not much more vague and inattentive to this issue. Nor do I recommend a movement to define "neglect," If that merely adds to the burdens of parenthood without concurrently providing the resources most parents want.

And what do parents want? In the fall of 1982, the Center for Early Adolescence polled parents of 10- to 15-year-olds to learn about their worries and preferences regarding their children's activities in the after-school hours.[72] The parents whose voices ring through the answer sheets are black, white, Hispanic, female, male, urban, rural, and suburban. They worry most about their young adolescent daughters' and sons' physical safety. They are also deeply concerned about their children's social and intellectual well-being.

The most striking finding of this survey, which 996 out of 2000 parents of 10- to 14-year-olds returned, is the similarity of parents' attitudes and needs regardless of marital status, level of family income, location of home, race, or their child's gender. The largest group of parents with pressing needs in the afternoon are those from households where no adult is at home after school lets out. Parents worry about not being at home to supervise their children. They worry most about safety: fires, kitchen accidents, traffic accidents, muggings. They worry about peer influence. They worry about whether they really know where their children are. They want them to do something constructive, to learn something, to have new experiences, to read more. The most frequently cited reasons for their children's lack of involvement in after-school activities are that the activities are not offered, the costs are too high, the children cannot get to the locations, and the children are already too busy. This last reason is cited by high-income parents. Low-income parents are most likely to cite cost and lack of transportation as barriers. One mother wrote, "Some families cannot afford private clubs or classes for their children. I feel that if more community activities were offered for all children, there would be less trouble with our youth."

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[70] Medrich et al., pp. 240–41.

[71] "How to Make Your Kids Street Smart," Family Circle, Mar. 13, 1979, p. 112.

[72] Anita M. Farel, "After-School Activities Questionnaire: A Preliminary Study of Parents' Preferences and Needs," mimeographed (Chapel Hill, N.C.: Center for Early Adolescence, 1983).

Medrich et al. found that 75 percent of mothers agreed that organized activities are an important part of any child's education.[73] In the Medrich study and in the Center for Early Adolescence's survey, parents' desires for their children run counter to current trends. As Medrich and Rubin say, "We seem to be witnessing a reduced public commitment to the rising generation . . . . With regard to after-school services and the supervised care they provide, the prognosis is not favorable: less service, less diversity in activities . . . and, in contrast with the expressed purposes of public sector programming, less social equity." [74]

Findings from the Montgomery County study are equally distressing and more surprising. When asked what form of child care they prefer, 87.9 percent of the 1,000 parents sampled answered that they prefer self-care. Only 12.1 percent would prefer something else, usually an after-school recreation program. The children being discussed are ages 0–13, and yet 71.6 percent of the parents feel the child is old enough to take care of himself or herself. While Montgomery County is not representative of the nation, this indication of greater parental acceptance of children's isolation in the after-school hours is new and deeply troubling.[75]

Adolescents are spending the after-school hours unsupervised and uninvolved in their communities at a time in their lives characterized by high energy, a striving for self-definition, and a need to prove their personal competence in a variety of areas. As we have seen in the statistical overview, they are vulnerable to the negative influences of their environment, their peers, and adults; but as we saw in the developmental overview, they are also vulnerable to positive influences, and, in particular look to adults as role models and sources of affection and guidance. Environments that offer realistic expectations of youth, caring relationships with adults, and diverse opportunities for constructive and enjoyable activities with peers will increase youths vulnerability to the best in themselves, their peers, and adults.

I believe that concern about after-school care for adolescents, especially young adolescents, will increase as the number of working mothers continues to increase. The pressures on communities to provide after-school care and the sheer numbers of unsupervised young teenagers will intensify public apprehension and lead to calls for greater social control of the young. At the same time, opportunities for enriching experiences during formative years should not be tied solely to labor force and social control issues. Parents cannot and should not be their adolescents' sole source of information or companionship. Given what we know about adolescents' need to become increasingly independent from their parents, adults other than parents must be available to them. Otherwise, we abandon our youngsters to the enlarging youth ghettos of the after-school hours.

AFTER-SCHOOL PROGRAMS FOR YOUNG ADOLESCENTS

Adults are stabilizing influences in the lives of adolescents. The after-school hours and vacation periods offer communities a golden opportunity to supplement families in molding young people's passage from the dependency of childhood to the relative independence of adulthood. Approached from this perspective, despite the fact that they are responding to dramatic current changes in American families, after-school programs are institutions imbedded in the American tradition of child-rearing, helping to recreate the coherence between family and community that has been the purpose of youth-serving organizations since the turn of the century.

The Center for Early Adolescence is making a concerted effort to call attention to the after-school needs of young adolescents. We have worked as a team of investigators identifying, observing, and documenting high-quality programs for 10- to 15-year-olds. We have visited 50 programs in 24 states that meet our criteria for quality after-school programs. We have selected 24 programs to document in a program catalogue, based on diversity of region, focus, sponsorship, funding sources, and program size.[76]

What have we learned from this effort to find and document effective programs for 10- to 15-year-olds?

Probably the hardest lesson we learned is the difficulty of identifying these programs. There is no network of professionals and volunteers among whom the reputations of excellent after-school programs are broadly known. We had a year's time and foundation funding to help us learn about achieving excellence from a variety

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[73] Medrich et al.

[74] Victor Rubin and Elliott Medrich, "Child Care, Recreation and the Fiscal Crisis," Urban and Social Change Review, 12, No. 1 (1979), 27.

[75] Telephone conversation with Millie Grant.

[76] Center for Early Adolescence, "3:00 to 6:00 P.M.: Programs for Young Adolescents" (Chapel Hill, N.C.: Author, 1983). Portions of this discussion have been adapted from the Introduction.

of programs. Youth workers who are not part of national organizations have no one to turn to for new ideas, mutual support, and information about what works and why. Parents are even more isolated, lacking printed materials that tell them what exists in their community and what criteria they should use in helping their adolescents select programs in the after-school hours. We learned that adolescents "vote with their feet" by attending after-school programs in community centers, museums, libraries, schools, churches and synagogues, Boys Clubs, Girls Clubs, 4–H, and the like. We learned that they attend because there is an adult who knows and understands them. While a particular activity may be the "hook" that draws teenagers in, their loyalty to the program is dependent upon the sensitivity of an adult who has time to listen and to care.

We learned that public institutions have been and still could be well placed as providers of safe, supervised recreation, academic and cultural enrichment, and counseling. But inflation, cutbacks in funding, and taxpayer revolts are taking their toll. Several examples will make the point. Given cuts in Title XX funds, day-care programs have been forced to institute new fee schedules. Parents have found they have to choose which of their children they can afford to send. They understandably choose to pay for their younger children and withdraw the older siblings, who thus become so-called latchkey children. Libraries find that more and more young adolescents (librarians call them "young adults") and using libraries as drop-in centers after school. Parents approve of their children going to the library, a safe, warm, supervised place where nothing bad can happen and homework can get done. Ideally, libraries should have "young adult librarians," people who specialize in serving the early and middle adolescent age group. These specialists can make the library a welcoming and enriching place for teenagers. With budget cuts, libraries have had to cut back not only on hours and acquisitions, but on staff. Because the young adult librarian's a position is one of the newest, it is also most vulnerable to such cuts. Likewise, municipal recreation departments have had to cut youth worker positions at precisely the time when more staff is needed to serve unsupervised teens.

One of the most dramatic cuts has been a change in eligibility in the child care food service program. The purpose of Section 17 of the National School Lunch Act is to assist states to "maintain or expand nonprofit food service programs for children in public and private nonprofit non-residential institutions providing child-care and private for-profit centers that receive compensation under Title XX for at least 25 percent of the children who are enrolled in non-residential day-care services." [77] In 1981, Public Law 9735 reduced the age eligibility from 18 to 12, except for migrants (the maximum age is 15) and handicapped (18) children. An analyst in the Nutrition Service of the U.S. Department of Agriculture estimates that $5 million has been saved by not subsidizing the feeding of adolescents. (FY program costs were $322 million.) [78] One person contacted at the U.S.D.A. said blithely, "The age limit was 18, but the law has been changed. Now, although we do not bar older children from participating in programs, they may not eat the supplement if they are over 12 years of age. That is, we will not reimburse for these children." [79]

I suppose we should be grateful that older children are not being barred from after-school programs, and I suppose we should be grateful that they may eat—that is, if the program can figure out how to pay for the food, But I cannot be sanguine about the short-sightedness of failing to enhance the nutrition of adolescents during a growth spurt second only to infancy in velocity of the short-sightedness of failing to teach, through modeling, good nutritional habits to an age group whose attraction to junk food we publicly bemoan. We can imagine a scenario in comprehensive service programs where adolescents leave the building to go outside and buy soda and potato chips from a vendor, while younger program participants are being fed. While an 11-year-old needs that food, perhaps the 13-year-old who is growing 4 inches in one year needs it more. The only person in this scenario benefiting from the government's policy is the vendor, whose concern for adolescent nutrition is not apparent. We are saving $5 million, but we have no idea what we are losing in long-range costs.

In August 1982, the National Governors' Association adopted the following resolution about child care: "States should seek a balance of public support for families who require child care for developmental, protective, special needs, or work-related reasons . . . The Federal Government should expand tax credits and provide in-

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[77] "Child Care Food Programs," 1983 Catalogue of Federal Domestic Assistance, Section 10.558 (Washington, D.C.: GPO, 1983), p. 56.

[78] Telephone conversation with Fran Zorn, Analyst, Nutrition Service, USDA, Oct. 13, 1983.

[79] Telephone conversation with informant, USDA, Sept. 15, 1983.

creased monetary support for child care for low income families." [80] No age limits are stipulated. I strongly recommend that the Committee consider the 3:00 to 6:00 P.M. issue as it collides with the developmental needs of adolescents, and explore restoring the upper age limit of the food service program. I also recommend that the Committee explore other legislative barriers to providing services to adolescents in the after-school hours.

I would also suggest looking at NEH's Youth Projects, which promote activities in the humanities after school, on weekends, and on vacations, but which limits age eligibility to 16- to 24-year-olds. Why? Likewise, ACTION's Young Volunteers in Action Program, while open to 14- to 22-year-olds, needs Congressional attention to strengthen and even extend downward its program for the younger segment of its age range. Adolescents do not have to be a drain on the resources of their communities. They can, instead, be resources for their communities. Adolescents, when invited and encouraged, provide companionship to the elderly, take care of younger children in day-care centers, construct community playgrounds, counsel their peers, staff hotlines, plant and tend inner-city gardens, paint and weatherproof houses, serve as museum guides, volunteer with handicapped children, staff candystriper programs in hospitals, do food shopping for the housebound, shovel snow, clean parks . . . Their energy is proverbial. The question is only how the energy will out, whether it will be against us, against themselves, or on behalf of us all. Gwendolyn Brooks, in a poem called "Boy Breaking Glass," writes, "I shall create! If not a note, a hole. If not an overture, a desecration." Sometimes, we must turn to poets to hear what we will not learn from our children.

I have presented a compilation of statistics that indicate a mixed picture of the status of adolescents in the United States. I have pointed to some characteristics of normal adolescent development that make adolescents vulnerable both to negative and positive influences. I have discussed the 3:00 to 6:00 P.M. problem as the epitome of an issue in which changes in families and the labor force converge with characteristics of adolescent development to require social attentiveness and commitment. I have not struggled with definitions of prevention and intervention because, as is so often the case in youth services, the terms become interchangeable.

We will never perceive ourselves as not having a youth problem. From the time of the colonies, adults have bemoaned the incorrigibility of youth. In fact, one can quote ancient Egyptians and Aristotle on the youth crisis. Whether or not we have a youth crisis, there are youth in crisis. If we can marshall our resources on behalf of these young people, we will have done part of our job. Some would say we will have done all our job. They believe that the most feasible and desirable youth policy is one targeted on "demonstrably unlucky children whose bodies or minds are sick or whose families are unstable or in poverty." [81] I agree that this is the most feasible policy, but I cannot agree that it is the most desirable. While we wistfully yearn for a long-gone and perhaps mythical time when neighborhoods were communities, people knew and cared about each other, and folks sat on the front porch sharing the week's news, we have left out of our fantasy something that was very real: the communal sense of responsibility for watching over and rearing teenagers. Families should not have to be demonstrably inadequate in order to be helped in offering their children a rich array of experiences and opportunities. Children should not have to be from failed families or in crisis themselves in order to receive from adults the enlarged vision of themselves that their future so depends on.

Adolescence is not preparation for life. It is life. The 3:00 to 6:00 P.M. issue challenges us to do for adolescents in the after-school hours what we must then do the rest of the day: to define meaningful social roles for youth as they mature into the healthy, responsible, fulfilled adults we wish them to become.

Mrs. BOGGS. Thank you so much, Dr. Lipsitz.

We have a vote on in the House. If some of you were worrying about the various bells that are ringing, they are reflected in the clock back there. The red light means that we are in session and the other lights indicate what the action is on the House floor.

If the members would like to leave to answer the rollcall, we will come back and hear you, Kim, please. Please, Doctor, don't leave

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[80] "Proposed Changes in Policy," National Governors Assocation Committee on Human Resources," mimeographed, August 1983.

[81] Gilbert Y. Steiner, "The Children's Cause" (Washington, D.C.: The Brookings Institution, 1976), p. 255.

because we want to have Kim and Mr. Dyak testify and then we will question the whole panel together. OK. Thank you.

[Recess.]

Mrs. BOGGS. Since our first opening meeting, we have been joined by Congressman Wolf and Congressman Marriott and Congressman Coats. I wonder if any of them would like to make an opening statement?

Mr. MARRIOTT. Madam Chairman, I would just like to congratulate you for holding these hearings. This is a very important subject and I am happy to be here and take part.

Mrs. BOGGS. Congressman Coats.

Mr. COATS. I also want to congratulate the chairwoman for holding these hearings and look forward to the testimony. I regret that I am bouncing back and forth between a markup on the telephone bill downstairs and can't give you my undivided attention, but this certainly is an important subject and I commend you for your list of witnesses and the hearing.

Mrs. BOGGS. Thank you so much. Better communications up here, Mr. Coats.

Congressman Levin has also come in.

Mr. LEVIN. I have no opening statement. I am in the same predictament so excuse me if I am back and forth.

Mrs. BOGGS. We are very happy to have you here—both of you—for as long as you can stay with us, and especially happy to see in the room so many peers who are here covering peers for their own school papers and various other types of journalistic endeavors that they are engaged in.

I am very happy to have all of you here, especially since I have a grandson who reports for the Whitman High News. I wish he were here, too.

We are so pleased, Kim, to have you with us.

Ms. FIELDS. I am so happy to be here. Thank you very much for having me here.

Mrs. BOGGS. Thank you. Mr. Dyak, we congratulate you for being with us and for making certain that Kim is with us today. We are so happy to hear from you. Kim Fields.

STATEMENT OF KIM FIELDS, COSTAR OF TELEVISION SERIES, "FACTS OF LIFE," ACCOMPANIED BY HER MOTHER, MRS. FIELDS

Ms. FIELDS. Members of the task force, I am here today representing the Youth Rescue Fund, Inc. at the request of the fund's board of directors. I am accompanied by Brian Dyak and Rev. Stephen Rorke, both officers of the fund's board of directors. Both of the gentlemen have substantial national experience working with issues surrounding teens in crisis.

I would like to express my personal appreciation and that of the Youth Rescue Fund and its members for the support that this committee is giving to the issues that affect teenagers. I especially commend this committee for their leadership and dedication to encourage Congress to look into the future of our country by listening to the needs of teenagers today.

The Youth Rescue Fund is a national organization dedicated to increasing the public's awareness about teenagers in crisis. The

fund was started by two of my peers, Matthew and Patrick Laborteaux, upon realizing that teenage actors and actresses could play an important national role to further programs and services for teenagers that need help because of involvement with drugs, alcohol, prostitution, pornography, abuse and runaways.

The fund has organized the celebrity peer council comprised of over 15 teenage actors and actresses who have committed their time to the fund's national programs. One national program is taking place in 16 cities to create awareness about teens in crisis, and driving under the influence of drugs or alcohol. The fund's overall national program has been implemented in all 50 States.

The fund has also organized peer councils comprised of teenagers who help other teens. Local peer councils are established in keeping with the fund's philosophy of youth helping youth. Many teenagers write to the fund, especially after one of our television shows highlights a specific teenage issue, such as teenage pregnancy, or teen suicide.

We provide these teenagers with a peer council handbook that encourages teenagers to get involved in their schools and community. An example of the work of the fund's local peer council is occurring today in San Diego, Calif. I would like to share this work with you so that you can understand the important role teenagers can play in addressing their own needs.

George Tubon, a 16-year-old that became aware of the Youth Rescue Fund through the media, has organized over 30 teenagers who care about teenagers and who are at risk of being in crisis.

George organized a week-long awareness program about teenagers in crisis within the San Diego County school system. George has recruited community youth agencies to address teenagers about their services during lunchtime. The school system has declared "Youth in Crisis Week," and has supported the peer council members' efforts to bring important information from community services directly into the school system.

Agencies participating offer peer counseling programs and services for teenagers that are runaways, homeless or messed up because of drug or alcohol use. Another example would be that of the San Diego peer council and Omaha, Nebr., peer council. These councils are sponsoring student-organized health fairs in their schools to provide teenagers with useful information about basic hygiene and information about street diseases.

The Youth Rescue Fund has joined with the national health fair program to promote health fairs nationally as an example of the value of youth helping youth. All of the fund's programs emphasize youth leading efforts to help other youth.

I would now like to take some time to explain to you why I am involved in the work of the Work Rescue Fund and why I care about helping other teenagers.

I have been blessed to have an opportunity to work and be recognized by young people across the country and I care about what is happening to the young people today. When I get a script that has some real essence, I really have to prepare myself to be aware of how teenagers might feel in a crisis. This means getting in touch with the pain, the problems and the hurts that happen to kids.

"Facts of Life" is a very real show in portraying a lot of what teenagers are going through when confronted with drug use, runaways, pregnancy, and even suicide. Speaking of suicide, our show often touches bases with reality. In fact, each time we do a show with a social comment, the producer and all of the costars on the show get some very painful letters from our fans or others who are concerned about the issue expressed on the show.

These letters are a constant reminder about how real the problems are facing teenagers and their parents. Often the letters are very sad and you hope and pray that things will get better for them.

Right now I would like to share a story that we got in a fan letter about this girl. About 3 years ago, we did a show on teenage suicide and this girl had seen it on a Wednesday night. Friday night, her parents were giving a big party.

This girl felt that she could not cope with life and the difficulties of becoming—of growing up as a teenager. She was going to commit suicide Friday at the parents' party and—make a big scene. Wednesday night, our show came on dealing with suicide. We had a girl in the show who felt that she couldn't deal with it all. As a matter of fact, she was an ambassador's daughter and she felt that she couldn't deal with all the problems—that she was facing and she committed suicide. But the thing was after the girl on the show committed suicide we talked about it and discussed how she could have overcome her problems and just talked about it with either other friends or a hotline or something.

This girl in real life stopped herself from committing suicide that Friday because she had seen our show. That is very touching to me because I know that I was on that show and helped a great deal in saving a life.

My costars on the show and a number of other teenagers and actors and actresses hang out together and often we talk about our scripts and shows that touch on issues affecting many kids. We all realize that supporting each other in efforts to be good actors and actresses is an important aspect of our work.

We also accept our responsibility to those that we may influence because of a certain character or part we play on a show. In accepting that responsibility, we have to recognize that peer pressure is a powerful force that has the potential to either misdirect a teenager's life or hopefully direct a teenager into a healthy life, making a positive contribution to others and others in the community.

The youth-helping-youth philosophy of the Youth Rescue Fund and my participation in the Fund Celebrity Peer Council are ways for me to reach others to let them know that kids are important and can make valuable contributions to society, not only for the future, but right now.

Teenagers are underutilized resources for making the quality of life better for all people. Teenagers, when given the opportunity, are part of a solution to helping teenagers in crisis, they are not the problem.

Adults have an important role to play to encourage kids to be sensitive and helpful to other kids that may have troubled times. Adults as role models must realize that we kids look up to them for guidance, support and direction as to how we live our lives.

Every time an adult messes up by getting drunk and driving, or using drugs, it confuses kids, a lot of kids, especially if the adult is a parent, celebrity, or sports hero that a kid looks up to as a role model.

Adults must realize that many of the kids in crisis are in crisis because of the lack of a good home, support or self-esteem that is generally provided to kids by adults.

We must pull together in uniting adults and kids to work together in the best interest of a healthy society.

Together we can make a difference. The Youth Rescue Fund is a perfect example of the youth/adult partnership necessary to help others. This committee is also a good example.

Kids need to know that Congress listens to them even though we don't vote.

Kids must know that their opinions and ideas are valued by leadership and be given an opportunity to participate in this society to help create the future that we will inherit. The reality is that many kids are in crisis.

If we work together and churches increase their outreach missions, social service agencies and government make room for kids to participate in programs and decisionmaking, and we make a goal and promise ourselves that we will fight to reduce the number of teenage suicides; we will combat drugs; we will strive to have a means to support kids bordering crisis or already in trouble.

I believe that we can make a more caring society and better quality of life for everyone. I don't think this is a dream. It is just a commitment that kids and adults have to make to each other.

Kids are nearest to solutions and can play a valuable role in reaching their peers with a message of faith and hope that life is worth living and can be better. Together kids and adults can find solutions to the many tragedies that place kids in crisis.

I hope and pray that the work of the Special Committee on Children, Youth and Families and the important work of youth-helping services becomes clear to the public. Some day, I hope we may be able to celebrate that all people are aware of the needs of teenagers and that youth in crisis was a national tragedy that was a part of our past and not a part of our future.

If we continue to work together, we will be able to prevent losing an entire generation to street life, and the pain of loneliness, low self-esteem and depression. Our commitment will make the difference in the lives of many teenagers and adults.

Thank you, again, for the opportunity to be here. I would like to thank Brian Dyak for helping me prepare my testimony and thank the members of the committee and Mr. Ron Laborteaux, president of the Youth Rescue Fund Board of Directors, for giving me a chance, as a 14-year-old, to be heard. This is one experience that I will never forget in my life.

Thank you very much.

[Prepared statement of Kim Fields follows:]

PREPARED STATEMENT OF KIM FIELDS, FOR THE YOUTH RESCUE FUND INC.,

Members of the Task Force, I am here today representing the Youth Rescue Fund Inc. at the request of the Fund's Board of Directors. I am accompanied by Brian Dyak and Rev. Stephen Rorke, both officers of the Fund's Board of Directors. Both

of the gentlemen have substantial national experience working with issues surrounding teens in crisis. I would like to express my personal appreciation and that of the Youth Rescue Fund and its members, for the support that this Committee is giving to issues that affect teenagers. I especially commend my fellow Californian, Congressman George Miller, Representative Lindy Boggs, Representative Dan Mariott and Representative Hamilton Fish for their leadership and dedication to encourage Congress to look into the future of our country by listening to the needs of teenagers today.

The Youth Rescue Fund is a national organization dedicated to increasing the public's awareness about teenagers in crisis. The Fund was started by two of my peers, Matthew and Patrick Laborteaux, upon realizing that teenage actors and actresses could play an important national role to further programs and services for teenagers that need help because of involvement with drugs, alcohol, prostitution, pornography, abuse and runaways. The Fund has organized a "Celebrity Peer Council" comprised of over fifteen teenage actors and actresses who have committed their time to the Fund's national programs. One national program is taking place in sixteen cities to create awareness about teens in crisis, and driving under the influence of drugs or alcohol. The Fund's overall national program has been implemented in all fifty states.

The Fund has also organized "peer councils" comprised of teenagers who want to help other teens. Local "peer councils" are established in keeping with the Fund's philosophy of "Youth Helping Youth." Many teenagers write to the Fund especially after one of our television shows highlights a specific "teenage issue" such as teenage pregnancy, or teen suicide. We provide these teenagers with a Peer Council Handbook that encourages teenagers to get involved in their schools and community. An example of the work of the Fund's "local peer council" is occurring today in San Diego, California. I would like to share this work with you so you can understand the important role teenagers can play in addressing their own needs.

George Tubon, a sixteen year old that became aware of the Youth Rescue Fund through the media, has organized over thirty teenagers who care about teenagers who are at risk of being in crisis. George asked the Fund to help him initiate a Youth Rescue Fund membership campaign and to organize a week long awareness program about teenagers in crisis within the San Diego County School System. The school system agreed that it was important to get information from community youth service agencies to teenagers about "how they can get help." George and a number of other peer council members have recruited community youth agencies to address teenagers about their services during lunch time. The school system has declared "Youth-in-Crisis Week" and has supported the peer council members efforts to bring important information from community services directly into school. Agencies participating offer peer counseling programs, and services for teenagers that are runaways, homeless or messed up because of drug or alcohol use. Another example would be that of the San Diego Peer Council and Omaha, Nebraska Peer Council. These councils are sponsoring student organized health fairs in their schools to provide teenagers with useful information about basic hygiene and information about "street diseases." The Youth Rescue Fund has joined with the National Health Fair Program to promote health fairs nationally as an example of the value of "youth helping youth." All of the Fund's programs emphasize youth leading efforts to help other youth.

I would like to take some time to explain why I'm involved in the work of the Youth Rescue Fund and why I care about helping other teenagers.

My acting career began when I was five years old, mostly doing commercials. I was fortunate a few years ago to get a part in the NBC hit series about four girls in boarding school, "The Facts of Life." My other television credits include appearances in "Different Strokes," "Mork and Mindy," and "Good Times." I've also appeared in a number of television movies, including the mini-series "Roots" in which I played Alex Haley's daughter. Comedy comes easy to me, but not drama. Many times a producer shapes a movie or series to include both comedy and drama. My awareness about other teenagers has developed as I've prepared for different acting parts. For example, I played a gymnast Olympic contender who turns to alcohol following her parent's divorce in the NBC-TV movie "Children of Divorce," and most recently I played a girl who has a poor relationship with her father in NBC-TV's movie of the week, "The Kid with the Broken Halo." Several episodes of "The Facts of Life" have been especially written to focus on issues that affect teenagers. For example, we did an episode on teenage suicide, and another on teenage drinking and driving.

When studying for these parts, I really have to prepare myself to be aware of how teenagers might feel in crisis. This means getting in touch with the pain, problems,

and hurts that happen to kids. "The Facts of Life" show is very real in portraying what teenagers go through when confronted with drug use, runaways, pregnancy and even suicide. The show often touches base with reality, in fact each time we do a show with a social comment, the producer and all of us on the show get some very painful letters from our fans or others who are concerned about the issue expressed on the show. These letters are a constant reminder about how real the problems are facing teenagers and their parents. Often they are very sad and you hope and pray things will get better for them.

My co-stars on "The Facts of Life" and a number of other teenage actors and actresses hang out together. Often we talk about our scripts and shows that touch on issues affecting many kids. We all realize that supporting each other in efforts to be good actors and actresses is an important aspect of our work. We also accept our responsibility to those that we may influence because of a certain character or part played on a show. In accepting that responsibility, we have to recognize that "Peer Pressure" is a powerful force that has the potential to misdirect a teenager's life, or hopefully, direct a teenager into a healthy life making a positive contribution to others and our communities.

The "Youth Helping Youth" philosophy of the Youth Rescue Fund, and my participation on the Fund's "Celebrity Peer Council" are ways for me to reach others to let them know that kids are important, and valuable contributors to society not only for the future but right now. Teenagers are an under utilized resource for making the quality of life better for all people. Teenagers, given the opportunity, are a part of a solution to helping teenagers in crisis, they are not the problem.

Adults have an important role to play to encourage kids to be sensitive and helpful to other kids that may have troubled times. Adults as role models must realize we kids look to them for guidance, support and direction as to how we live our lives. Everytime an adult messes up by getting drunk and driving or using drugs it confuses a lot of kids, especially if the adult is a parent, celebrity or sports hero that a kid looks to as a role model. Adults must recognize that many of the kids in crisis are in crisis because of the lack of a good home, support or self-esteem that is generally provided to kids by adults.

We must pull together in uniting adults and kids to work together in the best interest of a healthy society.

Together we can make a difference. The Youth Rescue Fund is a perfect example of the youth/adult partnership necessary to help others. This committee is also a good example.

Kids need to know that Congress listens to them even though we don't vote.

Kids must know that their opinions and ideas are valued by leadership and be given an opportunity to participate in society to help create the future we will inherit. The reality is that many kids are in crisis, it is a fact of life.

If we work together and churches increase their outreach ministries, social service agencies and government make room for kids to participate in programs and decision making, and we make a goal and a promise to ourselves that: we will fight to reduce the number of teenage suicides; we will combat drug use; we will strive to have a means to support kids bordering crisis or already in trouble . . . I believe we can make a more caring society and a better quality of life for everyone a "fact of life."

I don't think this is a dream, it's just a commitment that kids and adults have to make to each other.

Kids are nearest to solutions, and can play a valuable role in reaching their peers with a message of faith and hope that life is worth living and can be better. Together kids and adults can find solutions to the many tragedies that place kids in crisis.

I hope and pray that the work of the Special Committee on Children, Youth and Families, and the important work of youth helping services becomes clear to the public. Someday, I hope we may be able to celebrate that all people are aware of the needs of teenagers, and that youth-in-crisis was a national tragedy that was a part of our past and is not a part of our future. If we continue to work together we will be able to prevent losing an entire generation to "street life" and the pain of loneliness, low self-esteem, and depression. Our commitment will make the difference in the lives of many teenagers and adults.

Thank you, again, for the opportunity to be here. I'd like to thank Brian Dyak for helping me prepare my testimony, and thank members of the Committee, and Ron Laborteaux, President of the Youth Rescue Fund Board of Directors, for giving me a chance, as a fourteen year old, to speak and be heard. This experience is one that I will remember for the rest of my life. Thank you.

Mrs. BOGGS. Kim, this is an experience we will never forget, dear. Thank you so very much.

Mr. Fish has come back into the committee and I wonder if he would like to make an opening statement of any kind?

Mr. FISH. No, thank you, Madam Chairman.

Mrs. BOGGS. We are so pleased to have both of you with us and now we would open to questions for both Dr. Lipsitz and for Kim and Mr. Dyak, if he so desires.

Dr. Lipsitz, we know that you have given us so much good data about the information gap that exists on what is done about supervision in afterschool hours and school vacation days for young people.

Can you tell us how communities that have good programs are able to finance them and do you see any role for government in the financing of these afterschool programs?

Ms. LIPSITZ. Yes, the programs that I have visited in 24 States are funded in very varying ways. Most of them—at one point, I called it an archeological dig because so many of them were going under that when I would get to the places where I thought there was a program, it had just gone under.

Some of them, as I tried to indicate in my statement, are being destroyed by cuts in title XX because they—it is the straw that breaks the camel's back—they can't feed the kids and so they have to lose them.

Some of them have gone on to fee schedules. Some of them are United Way agencies and there is a particular struggle to get some of the programs for the adolescents into United Way at a time when there is so much competition now for United Way funds. It is difficult to create another slice of the decreasing pie.

Some of them are remarkable. Some of the directors are remarkable in the way they get the funding and two of those programs can answer that question for you later. One of them, Levels—and Joe Covino will be here—gets its funding from the library budget. The other one, Rheedlen, gets its funding from State and Federal funds and very honestly, many of these programs, including Rheedlen, redefine their purpose, their stated purpose, although they do not redefine what they do, based on the vagaries of political interest so that if we are interested in runaways, they can become a runaway prevention program, and if we are interested in foster care, they can become that kind of program and they are very entrepreneurial about doing that.

You have to be a real go-getter, very entrepreneurial, and you have to have the time and energy to do that. Now some of the programs are private. They are church- and synagogue-supported, but most of them that I visited that I considered superb were deeply dependent on public funding.

Mrs. BOGGS. Thank you. Both you and Kim seem to emphasize the fact that youth and adults have to work together and in mutual respect and understanding and in an effort to resolve problems and to meet challenges.

Kim, I wonder if you have any advice for this committee on what part the Government could play, what kind of legislation, perhaps, we could adopt that would be able to be helpful to your program, especially the youth helping youth and the fact that the Youth

Rescue Fund does have a combination of youths and adults together.

Do you think there is anything we could do to be helpful to you?

Ms. FIELDS. I think that if everybody just became more sincere, and I just thank you all so much for just even recognizing young people, but I think that if everybody became more sincere in really trying to help young people get their acts together, and adults as well, to make everything a little better. I think right now, that would be the best thing that anybody could do, whether they are Government or just somebody walking down the street. I think the sincerity at this point in time really counts.

Mrs. BOGGS. Thank you.

Mr. Dyak.

Mr. DYAK. May I add something. We were all up very late last night——[Laughter.]

In a very emotional time. Some of the trials and tribulations of developing Youth Rescue Fund over the last 2 years in working with Kim and a number of other young actors and actresses has brought to our attention that the youth peer pressure, as a key mode to get the message to the American public about the current status of young people in society has got to be utilized.

There are over 15 young celebrities that have committed to the fund and we are committing to this committee to make ourselves readily available. In fact, Kim's mom is here and we were talking, "Well, why didn't we do a press conference before we left LA," to really help this committee get its work done?

As far as a specific piece of legislation, yes, the fund or its directors would like to see a specific piece of legislation that totally addresses the issues of youth in crisis that ideally broke down some of the barriers that are caused by categorical programing and funding and that realized that kids are whole people.

That is basically it in a nutshell.

Mrs. BOGGS. Thank you so much, Mr. Dyak. We must indeed compliment Mr. Miller, who had that feeling for quite some time and was really the driving force behind the formation of this committee. We were concerned that youth programs and programs concerning young people were indeed fragmented into various jurisdictions in the Congress. We needed a holistic approach and we need to treat persons, of whatever age, as whole persons and to attack the problems in that fashion.

We accept with pleasure the offer of using the peer council members to help us in our work and we are very grateful to you for your testimony.

Ms. LIPSITZ. Mrs. Boggs, might I add that I had the privilege of going to the National Governors' Association meeting this year and one of the things that was very striking to me is that almost every resolution that was passed about children stopped at age 12. Those people who are really committed to working with adolescents are an endangered species, not because their commitment is waning, but because the social commitment to supporting their work is waning.

Mrs. BOGGS. I was particularly struck by your mention of nutrition programs. I can remember once having my three teenagers at a drugstore counter and one of my aunts came in horrified because

they were having ice cream sodas at 5 in the afternoon and she said, "Aren't you afraid that's going to ruin the children's appetite for dinner?" and I said, "Oh, Nanny, I hope so." [Laughter.]

Mr. Miller

Chairman MILLER. Thank you, Madam Chairman.

One thing that seems to be present in both of your testimonies is that teenagers in crisis are a shared responsibility. Kim, you make it very clear that adults need to be role models and, Dr. Lipsitz, you do the same thing in terms of suggesting that it is how we characterize young people and the role models that we present to them.

I would assume in the Youth Rescue Fund that there are adults who provide leadership and direction for the young people to go out and provide that kind of peer counseling, peer pressure, if you will, as positive role models?

Is that correct? I think it is very important that we understand that from the outset, that this is—teenage crisis does not appear to be, in reading through all of the testimony that we will hear today—does not appear to be one that will be solved either by teenagers alone or adults alone. One of the things, Kim, I think, a very, very important point you make to this committee is really an underlying point in your testimony that teenagers' views have got to be given some dignity, that they have got to be respected, that they can't be dismissed simply because they come from a 12-year-old or a 14-year-old or an 18-year-old that have a lot of other things going on in their mind and the body.

But if adults will start to respect some of those opinions and listen, then perhaps that partnership can be formed. It is very interesting that we heard in our Florida regional hearings from Nat Moore, who is a wide receiver for the Miami Dolphins, who again talked about the need for role models in the community for young people.

Dr. Lipsitz, you testify as to the emergency, which I guess became the subject of a song, "Valley Girls," of hanging out in the mall and gagging on a spoon or something. [Laughter.]

Mrs. BOGGS. Do you know how they are dressed, too? [Laughter.]

Chairman MILLER. I come from the northern part of that State, not the San Fernando Valley, but with two teenage sons there is, sometimes the temptation for them to go to the mall and to hang out. You need not be there very long before you discover that this is becoming a major source of recreation in the country. I think it is a matter of concern. It is not to fix blame on the malls for that; it is really a question of what kind of resources do we provide for young people during their waking hours, whether school is in session or out of session.

I think we can draw some conclusions and that the number of teens at the malls point out an absence of resources in a community, whether it is parks or boys clubs, girls clubs or organizations like Youth Rescue. The mall is kind of an indicator of the absence of other programs in the community. I just wonder—you brought it up in your testimony, to what extent are the number of children that we see—as you call, the "children from 3 to 6 p.m." really in this predicament because there are no other resources available to them?

Ms. LIPSITZ. It is a large percent and let me reassure you that it is not just California. I have clippings from Tuscaloosa, Ala., about children who go to the mall and stay there actually till all hours of the night. One thing is that there is transportation to the mall and I think that is an important factor for us to note, that most communities will make sure, most merchants will make sure that people have a way to get to the mall. I am talking about public transportation.

There is not very often public transportation to many of the other services that might actually exist in a community. Kids might not be able to get to the library. In fact, in the Oakland study that I cited, those youngsters who lived in the hills were less likely to be able to get to whatever services did exist, but there is definitely a dearth of services in most communities, whether urban or suburban or rural.

From what I can tell, the places that are richest in their resources are those areas that do have the settlement house tradition from the turn of the century, and who don't see it as being radical to be providing services for youngsters.

Chairman MILLER. Kim, you are obviously a very busy young person, between school and acting and the other chores that you have taken on, such as the Youth Rescue Fund. What do you think about your peers? Do you think most of them desire more directed time after school, on the weekends, in terms of programs or are they happy with this situation as it is?

Ms. FIELDS. When you say "peers," do you mean peers meaning, like, people I act with or other kids my age——

Chairman MILLER. Well, that is—you kind of cross both communities because you spend a lot of time with people in your profession, but in terms of your age group and your conversations and your knowledge of other young people in your age group, what is your impression, if you have one?

Ms. FIELDS. I am not sure that I have one just yet, because I think that, like the doctor was saying, that if there was, you know, transportation open to, let's say the library, where it is easier to get to the malls because it is just a very general place, but right now, I think I am just going to be very open about it until I know more about the situation.

Chairman MILLER. One of the things that happens on "Facts of Life" is that at about 22 minutes after the hour, the solution comes along, either the understanding friend or the adult comes into the scene to take care of the crisis. Either you sit around in the bedroom complex of the show and you discuss what happened and you help the person out of the dilemma or it is down in the kitchen and the housemother is helping somebody out with her words of wisdom.

One of the things we see in teenage crisis is really that those resources, either in the family or in the community, are not readily available or young people aren't as knowledgeable about them as they might be at that moment of their personal crisis.

How does the Youth Rescue Fund outreach to tell young people there is this support group of other adolescents who could be of help or help them find people who can help them?

Ms. FIELDS. Well, we do it by newsletters and by the media and—Brian.

Mr. DYAK. People like George Tubon, who gets the kids together and the parents and decide that they want to try to do something.

Chairman MILLER. Do you find young people seeking out members of the groups?

Mr. DYAK. Yes, in fact, we started—about 9 months ago, we started dealing with Matthew and Patrick Laborteaux's fan mail and if you take a look at the 15 young celebrities and the kind of fan mail they get, you are talking hundreds of thousands of letters. I mean, in the 4 to 5,000 range per month.

Chairman MILLER. A politician would give his heart to have that. [Laughter.]

Mr. DYAK. Really. Like when Kim did the drunk-driving show—we were talking last night, Matthew did a show on drug abuse on "Little House on the Prairie." The fan mail changes. The teen magazines have been carrying articles about the Youth Rescue Fund, and all of a sudden, the fan mail goes from, "I really love the color of your eyes," and "I think you are a foxy lady," to "What can I do to help?"

We are sitting on literally thousands of——

Chairman MILLER. Of young people who would like to be involved.

Mr. DYAK [continuing]. Of young people that want to help. So we are basically testing models in different cities to see what the shortcomings are going to be on some of that. I mean, there is a reality there that certainly George Tubon in San Diego made us come to grips with is that there are some real wackos out there, too, that when they see some kids trying to do something good for kids, there are some people that would like to take advantage of that.

That has made us move into a position of making a partnership happen between the young people and some parents. So there are ways, and I think that we are just—we are on the tip of the iceberg of ways to see literally tens of thousands of kids——

Chairman MILLER. But you are also on the tip of the iceberg of a number of young people who really want to make a contribution.

Mr. DYAK. Yes, and it is even—their shows are airing in foreign markets around 9–10 months after they air here, and they probably think Kim is around 11 in Japan, but the fan mail that we are getting, the international fan mail that we are getting, is starting to look somewhat the same way because the teen magazines in those countries are translating "16" magazine or "Tiger Beat" magazines, stories about what the kids are doing with the funds and what the issues are about American kids.

Chairman MILLER. Thank you very much for your testimony.

Mr. DYAK. Thank you.

Chairman MILLER. Kim, One of the reasons members serve on this committee is that we wanted to make very sure, that children did have a voice, even though they didn't vote. You have been a very, very articulate spokesperson here this morning and I think one of the role models that we would be delighted to help project.

Thank you very much for your time, and Dr. Lipsitz.

Mrs. BOGGS. Mr. Marriott.

Mr. MARRIOTT. Thank you, Madam Chairman. I appreciate speaking out of order. I have to go testify before another committee in 10 minutes, but I wanted to ask a few questions.

First of all, Kim, I want to thank you for coming. You gave a great testimony and you are a beautiful young lady. Is that your mother sitting behind you?

Mrs. BOGGS. Can't you tell? [Laughter.]

Ms. FIELDS. That is my mother.

Mr. MARRIOTT. She looks exactly like you and I want to congratulate both of you for what you do.

I have interviewed in the last number of months hundreds of young kids, 12 to 16 years old, kids who have been in trouble. I have consistently found two overriding factors of these kids. Most of them come from broken homes and none of them feel very good about themselves.

I want to ask you what you think kids can do with kids. You are talking about this Peer Council, which is a great idea. What can we do or what can kids do with kids to help each other feel good about themselves?

I assume people won't be in crisis situations and won't be anticipating suicide if they feel good about themselves. What do you think we can do—we ought to do, or kids ought to do to get the message out to help people, young people, feel good about themselves and feel some hope in the future?

Ms. FIELDS. I think the biggest thing as I mentioned in the testimony and in talking to Mr. Miller—would be to just let them be heard once or twice. Let them know that you respect what they are saying and that you understand what they are going through. From what I gather, just the fact that you formed this committee to have this hearing, that you do understand, I think that you understand what young people are going through in this time and I think that just letting them know that you do care, that you are interested in hearing what they have to say so that you can help them.

Second, I think that the Peer Council is probably another big thing because it is very helpful and I think right now, those are the two best things.

Mr. MARRIOTT. Do you think that kids in trouble from—maybe your friends are not in trouble and———

Ms. FIELDS. I have friends who are.

Mr. MARRIOTT. Maybe they are, but do you think that kids in trouble are getting a fair shake today? Do you think the system is such that there are places for them to go and people for them to talk to and other youth for them to associate with to help work out their problems or from what you can tell among your peers, are we lacking in the type of facilities we need to help kids?

Ms. FIELDS. I think that I am real glad that things are starting to happen, where facilities are being, you know, built or made or whatever, troubled youth are now realizing that they do have places to go, people to talk to, but I think a big thing that they really need right now is just a lot of support and a lot of understanding.

That is something that a facility can't really have. I think an individual needs to have that a lot more .

Mr. MARRIOTT. You need to have a lot of one-on-one——
Ms. FIELDS. Exactly.
Mr. MARRIOTT. [continuing]. Relationships——
Ms. FIELDS. Exactly.
Mr. MARRIOTT. [continuing]. With people who——
Ms. FIELDS. Which then again brings us right back to the Peer Councils.

Mr. MARRIOTT. Let me ask one other thing or just make one other comment. Some years ago, I sort of came down on television because there was so much junk being shown on TV and I took the philosophy that the only things you got out of TV were sore eyes and a hollow head. [Laughter.]

Mr. MARRIOTT. But since then, I have seen a lot of good things happen, good messages come across. Don't you think that we can do more with TV and that the TV industry can do more with their programing to make kids feel good.

Ms. FIELDS. Definitely.

Mr. MARRIOTT. You gave the example of how one of your programs helped a person overcome a desire to commit suicide. Shouldn't we be doing more; to focus on television programming since kids are watching TV more? Shouldn't we do more with TV in terms of really helping kids?

Ms. FIELDS. Definitely. Because of the big issue with the—I believe it is called "latchkey" children, that whole thing, that if they are not at the malls and they are at home watching TV from, what, 3 to 6, or whatever, and I think that that is definitely a very good point and that if the television media did have a lot of well, quality things going on with their shows or they are starting now to come out with these spots, you know, where they have spots about drunk driving and things like that. I think that that is a huge step in the right direction, but those are only spots and commercials and things like that. I think that the show itself could use—I think all shows could use a lot more improvement to help the youth since that is 99.9 percent of the audience these days.

Mr. MARRIOTT. Congratulations, Kim.

Mr. DYAK. Aside from looking at the producers and the directors, I think we really need to take a look at the advertisers, too. There is a real reality, I guess, for footing the bill there.

Mr. MARRIOTT. You think advertisers want sex and violence——
Mr. DYAK. Hey, it sells.
Mr. MARRIOTT [contining]. To sell their products.

Ms. FIELDS. I think so. I think that they want to push sex because it is still censored or whatever, but when you have children watching TV from 3 to 6 and that is still a cartoon—like, from 3 to 4 is still a cartoon time, and you see 6-year-old kids running around in tight jeans, I mean, that is the picture that they are going to get, whoever is watching.

I think the advertisers also have a great part of what is happening.

Mr. MARRIOTT. I think it is really critical that people in your position use your influence to promote good things and you are doing that. I want to congratulate you.

My time is up but one real quick question for the doctor, if I may. On latchkey kids, I have been sort of promoting the idea that

maybe schools ought to stay open later. Maybe from 3 to 6, and that we ought to get volunteers to come in and there ought to be some activity going on. I mean, not another program for the kids, who have been there maybe 6, 7 hours. They have had enough. But is there a way in your opinion with these latchkey programs that we could utilize the schools and a volunteer system to keep these kids off the streets and to take care of the problems with latchkey children?

Ms. LIPSITZ. I think that later you will hear from one program that does, in fact, use a school building in order to provide very fine services for youngsters in the after-school hours. There is a community school movement in this country which needs to be strengthened. In other words, the base is there. The buildings are there, and there is even in some places some commitment to it.

Those are some of the funds that are most quickly cut in a community when the crunch comes and so community school programs, in keeping these schools open in the after-school hours, that whole effort is in jeopardy.

Mr. MARRIOTT. Is that a good idea?

Ms. LIPSITZ. It is a wonderful idea.

Mr. MARRIOTT. Do you have any ideas on what they ought to be doing during that 3 hours?

Ms. LIPSITZ. They definitely need to provide, as you implied, the time to blow off steam, the recreation. But they also can provide, and do in some cases, academic enrichment, cultural enrichment, job counseling, sexuality counseling, crisis intervention, health care.

They provide meals if they have the money to provide the meals. There are such comprehensive programs using the school buildings. It costs money.

Mr. MARRIOTT. Thank you very much. Thank you, Madam Chairman.

Mrs. BOGGS. Mr. Fish is the ranking member of this task force and he has been gracious enough to give up his time, so Mr. Leland, if you will excuse me, I would like to recognize Mr. Fish now.

Mr. FISH. All right. I appreciate that. Thank you. Mr. Marriott—his last question brought up the subject that I thought that I was going to have exclusive rights to and be the person with great new insights here today. That is, the role of the schools.

Ms. Lipsitz, I don't think it is mentioned in your preparation. Maybe it is because it is being treated elsewhere, but we are talking about this 3 to 6 p.m. period and the need for adult supervision other than the parents. We have to assume this is the situation; we are not dealing with the lack of a parent and so forth, but we are trying to make up for it.

Then what about sports programs at schools? What about drama? What about some of these courses that take up the time in the morning and stick them in the afternoon? If they want to give you the cooking classes and things, teach the R's in the morning and fill up the afternoons like they do at independent schools so your athletic program will last until 5 in the afternoon. When you finish with that, all you want is supper and bed.

Studyhalls, supervised studyhalls, special help with the students, both faculty and other students, tutoring ones that need it. But I am thinking mostly—you mentioned the opportunities for all kinds of athletics instead of being free at 2, 3 and, of course, if you are not an athlete and you are interested in a school play, you know, have that time all afternoon for rehearsals, these are just a couple of things that came to my mind that can keep the kids there. You know, it would be easy because they have no place to go if the bus doesn't leave.

Mrs. BOGGS. That is a problem; the bus.

Mr. FISH. I am looking forward to testimony on the library relationship. I think the way you put it was marvelous: that teenagers are finding libraries as drop-in centers. As a library trustee with a meeting coming up very shortly, I want to know more about that if any of you have any comments.

The other question I guess I have—just throwing this out for anybody here is—well, I guess, Mr. Dyak, particularly you, would you tell us at some point how we get a Youth Rescue Fund operation in our respective districts?

And also, how do you steer the teenagers and channel their energy to what we were talking about, helping the elderly, working in day-care centers, counseling their friends, planting, what-not? Who gets the ball rolling to get this underway? I guess that is my question: the role of the school, the role of the library and how you steer teenagers to channel this energy.

Mr. DYAK. We will get you a Peer Council Handbook.

Mrs. BOGGS. Great, we would like one.

Mr. FISH. Thank you.

Mrs. BOGGS. I think each of us would like one.

Ms. LIPSITZ. Mr. Fish, one of the things that I have learned in midlife is that if I say I have three points to make, I always forget to make the third, so I may want to ask you to repeat your questions.

Mr. FISH. Sure.

Ms. LIPSITZ. First, in terms of the schools. I completely endorse what you are implying that schools could be doing. I would like to caution that many youngsters must work and do work in the after-school hours and we must not remove the arts, drama and enrichment and so forth from the in-school hours for these youngsters or they will have, I think, a very dry and deprived environment.

Mr. FISH. OK, right.

Ms. LIPSITZ. So I endorse what you are suggesting for the after-school hours school base, but I cannot go along with removing those aspects of the curriculum from the in-school hours. That is No. 1.

No. 2, as Mrs. Boggs whispered, the bus is a big problem and running double bus runs, if you keep youngsters after school, is expensive, as many of us know. So that if a community wants to use the school as the base for after-school programs——

Mr. FISH. Let's not call it "after-school." My school doesn't close till 5:30 or 6, the one I am talking about.

Ms. LIPSITZ. Well, that is a community school, then, and it is getting special funds.

Mr. FISH. No; I am talking in the future.

Ms. LIPSITZ. Oh, your school in the future is an expensive school.

Mr. FISH. Right. [Laughter.]

My State has just unfolded a program in response to all these—the 20th Century Fund and Nation at Risk and so forth, of over $2½ billion to respond to those studies and it is going to be expensive, but what you have been telling us and what we have been hearing for months is that the cost of inaction is going to be a lot worse.

Ms. LIPSITZ. A lot worse, so I would very much like to endorse what you said about what can be and should be and I think must be done in terms of cultural enrichment and recreation and counseling in the after-school hours. As to who gets it rolling, who gets the youth participating, I don't think—and I think you might have heard this is some of the rest of my testimony—I don't think that we should ask the 14-year-olds and the 13-year-olds of this country to take on that responsibility solely. We have a very unusual 14-year-old sitting next to us.

I might add that only now at age 14 could she take part in a community action program that would be supported by ACTION. Most of the ACTION programs barely do anything with 14- and 15-year-olds. She is not yet eligible to take place in any federally supported program in which she could be doing work in the community, like the National Endowment for the Humanities program, because the age cutoff is such that she could not start doing that until she is 16 years of age. So we could, in fact, look very much at the regulations, the age regulations that are precluding youngsters from taking place in programs that are already set in motion.

As far as other community participation on the part of the young, I think we have a very big—if you will excuse the term—consciousness-raising job to do in our communities about the fact that adolescents are not crazy, pathological, off-the-wall, irresponsible young people, unless we put them in that position.

If we invite them to join us in planning for the community, they will, in fact—and Junior League is starting to do this in some communities—the youngsters themselves are assessing the community needs and then deciding what it is that they, as junior high and high school youngsters, can contribute to their communities. They need to be invited back. I think our most segregated population in this country is the adolescent population. We need to reintegrate them into the community.

Mr. FISH. Do you care to comment on the third point, the use of libraries?

Ms. LIPSITZ. I would love to comment on the use of libraries because librarians are going crazy right now. Parents know that the library is a warm, safe place for kids to be, and if a kid says, "I will go to the library in the after-school hours," the parent is really comfortable.

So what is happening is that they are either dropping the kids off at the library, the kids are making their way to the library just at the point when taxpayer revolts and other cuts, inflation and other cuts, are making libraries seem to be frills in communities.

We need to staff—there is a whole profession, subprofession, within the profession of librarianship called Young Adult Librarianship. We need more——

Mr. FISH. Young Adults Librarian——

Ms. LIPSITZ. Young adults are the early and middle adolescent age group in librarians' jargon. These are some of the most talented youth workers in our country, young adult librarians. We need not to have these positions cut; we need to be adding these positions because the library is a wonderful place for semisupervised work and creative work, as you will hear from Levels.

Mr. FISH. Good. Thank you very much.

Mrs. BOGGS. Thank you.

Mr. Leland.

Mr. LELAND. Thank you, Madam Chairperson.

I have been chomping at the bit to get to my questions and all of a sudden Mr. Marriott almost stole all of my thunder because I definitely wanted to talk to Kim a little bit about television and programing and what they meant to her.

I am very, very excited about your testimony. I will tell you that I have been in politics now for 11 years, 5 years in the Congress, 6 years in the State Legislature of Texas, and I have never heard such compelling testimony—compelling as yours. I mean, it was just right on time, Kim. Thank you for being here and we are here to listen. We are here to hopefully help.

I am on also the Telecommunications Subcommittee of the Energy and Commerce Committee and we have been talking about children's programing; we have been talking about images of people in television and that kind of thing. You have probably seen some of the results when Sidney Poitier and some of your peers in the acting arena have come forward to Congress to talk about how poor television has been, particularly the networks, in their projection of images and positive and constructive programing.

You have just driven home, probably more than all of them put together, how important television is to the young people in our country. I am particularly pleased and excited about the analogy that you gave about the young person who wrote you the letter about committing suicide and how you felt that that really changed her mind about doing that.

Don't you feel that—if you can just expound on it a little more than what the response was to Mr. Marriott's question—don't you really feel that beyond just your show, that there ought to be more shows like yours on television? In other words, your network, and I am not—which network is that on?

Ms. FIELDS. NBC.

Mr. LELAND. NBC. Let me give plaudits to NBC. I have been jumping on them a lot——[Laughter.]

For a lot of things. Even though your show is a great example of positive programing for young people, there is just not enough of that. As a matter of fact, we ought to see competition with ABC and CBS with NBC about what is going on on NBC at your time. But don't you think that there just really ought to be more programing like that?

Ms. FIELDS. I will say yes, except—see, I don't want to, like, pat myself on the back——

Mr. LELAND. No; I want you to. I think you deserve to.

Ms. FIELDS. OK.

Mr. MILLER. Your mother will. She is right there. [Laughter.]

Ms. FIELDS. I think that you are absolutely right, that there should be a lot more programs. They just recently—I don't know about out here on the east coast, but back in California, they—this fall—have put us up against "Dynasty."

I think that that was a sin for a big reason—is that because we were such a, like, big hit——

Mr. LELAND. Yes.

Ms. FIELDS. We were a hit with most of, like, the young adults from—the beginning of teen years up to 23—and I think one—the network's reasons for putting us up against "Dynasty" was that because we were NBC—we are NBC's top show right now, and I think that they put us up against "Dynasty" ratingswise. They don't realize, though, that that hurts young people because parents will watch "Dynasty."

Now a lot of my friends say, "Well, don't worry about it because, you know, the kids are going to say, you know, 'I want to watch "Facts of Life." ' But I really don't think so because we have always come in No. 2 and that is fine—you know, the network, NBC is pleased with that. At least we are doing good—we are holding up against "Dynasty," but what they did not realize, consider or anything else was that it was really hurting the young people, because the young people can't watch it now because their parents are watching "Dynasty."

Two reasons that is not good is because, one, the parents are role models, as I said in my testimony, and if the young people see that they are turning off "Facts," you know, a very family-oriented show and blah, blah, blah, to watch——

Mr. LELAND. "Dynasty."

Ms. FIELDS [continuing]. "Ms. Thing" prance around in a fire, then I think that——[Laughter.]

I am sorry, but I think that that really hurts the young people, and it is not just, you know, I am worried about my ratings or anything like that. My viewpoint was for the young people and how that is just two conflicting things.

Mr. LELAND. As my colleague, the chairman of the full select committee has indicated, it begins a family argument. The young people want to watch "Facts of Life"——

Ms. FIELDS. Exactly.

Mr. LELAND [continuing]. And the older people want to watch——

Ms. FIELDS. Want to watch "Dynasty." Exactly.

Mr. LELAND. That is sort of counterproductive anyway, isn't it? Who is going to prevail usually in the house over television, particularly when "Dynasty" is on; right?

Ms. FIELDS. Exactly.

Mr. LELAND. Who is going to watch what? It is going to be the grownups who get to——

Ms. FIELDS. The next step is where you are on punishment; you can't watch TV for a week now.

Mr. DYAK. Excuse me, Mrs. Fields would like to make a comment on some of this, too, if that is OK.

Mr. LELAND. All right, I would love to hear from her.

Mr. DYAK. Get mom in on the action here now.

Mrs. BOGGS. Welcome, Mrs. Fields, we are so pleased that you came. It shows that adult/teenage cooperation really works.

Mrs. FIELDS. You know, I met you once before under a different heading. We were doing battered women and we did a movie. We came out and we spoke and I was in the hot seat then. Very uncomfortable, so I am just real proud of her, but I just wanted to address myself to what you said, Mr. Leland.

I think one of the things that is wrong with the television network concept is that—as when we were speaking with Mr. Marriott—the advertisers are calling the shots here. I mean, if I know that I am going to buy into a show that is going to get all of the people to buy my product, I am going to do that. If sex is what is happening, that is where I am going to put my money.

Unfortunately, I think one of the things that I think could be done realistically, and legislation could be very effective in helping this happen, when I go back, I am going to have this talk—I won't comment as an actress. I want to speak as a friend with Norman Lear and talk about what happened here today because he is very concerned with what Kim is doing. Because they get real nervous, you know, when you are going to go and you are going to open your mouth at the White House and you are going to say something. What are you going to say? [Laughter.]

The truth of the matter is, if we could get the Peer Council of those celebrities to turn the peer pressure around and let it become that you are a jerk if you are smoking drugs—but not necessarily the way they have been doing. What they have been doing is saying, "Let's get high on ourselves," or let's do this, and then it becomes this big national campaign that really is nothing but a lot of glitz. It is not really people who are really sensitive.

Kim and I, real specifically, are out here together. It is easy to send somebody with her, quite frankly, because I have other things—I have a baby to take care of at home, I have things to do.

Mrs. BOGGS. Of course.

Mrs. FIELDS. But it is important—I felt that this particular trip was going to be real important for me to be here because some people just don't believe that people spend time together anymore, mothers and daughters. We talk. We talk about, you know, the "Valley Girl" syndrome. We talk about meeting at the malls. We talk about the fact that Kim has crushes on people too young.

You know, we do talk about it and I think that one of the reasons that she will be an effective leader and a lot of the other kids on these shows will be very effective leaders is because they sit down and they really do have one-on-ones. I told Mr. Dyak, one of the things that is wrong with you being over here and us being over there is that the beautiful thing that I found from him and the people that are working with the youth rescue fund is not being communicated in Los Angeles. You got all these. How far is this going to go? I mean, you have got testimony here from people like Dr. Lipsitz—this woman is extremely knowledgeable about what needs to be done, but how far is it going to go? You will give them two seconds on NBC News, CBS News, and that will be the end of it.

How many young people are really going to have an opportunity to know this went on? This is an impressive forum for a kid to

know that another kid got a chance to sit here in front of you threatening adults and say a few things and say just what she thought. That is something that we don't see when we get back home. You don't take enough time with it.

We do need to get to the people like Norman Lear, who really does listen. He is a powerful man and he does listen. He does care, but he has money things he has got to worry about, too. He has got advertisers who are either going to buy into the show or they are not.

Now, in terms of "Dynasty" and "Ms. Thing" running through the fire, sweetheart——[Laughter.]

There are some things that are happening on shows like that that are very destructive, that if we could turn the peer pressure around in terms of getting scripts that, on Kim's show and other shows where teenagers are watching, that would try to make the feeling that it is much better to—I know you are not going to push in the next 10 years staying virgins until you get married. I know that is going to be hard to do—I'm doing it, but it's going to be hard to do. [Laughter.]

But I think if we started out—one of the things that Reverend Rorke said to his partner was that if we get to have dinner, no one is going to worry that we didn't eat lunch. If we get to the point where we have gotten some of these young people to start thinking about doing something else with their time, then don't worry about the fact that they are on the street; praise God they will be on the street; they will be bringing out on the street some good important things that other little kids will start to see.

But where is all the psyching going on? It's going on TV with the jean fad; it's going on with these Mohawk hairdos. Things are going on out there that people are not aware of.

Mr. LELAND. Mr. T is going to be mad at you.

Mrs. FIELDS. OK, I can handle him. I can handle him. [Laughter.]

There are things that we could address ourselves on television that I think legislation could put a little bit of a goose to people like Norman and some of the people who do make a difference that if they know that you are excited about it, they will get a little more excited about it and get a little more bold about doing something.

Thank you very much.

Mrs. BOGGS. Thank you.

Mr. LELAND. Thank you very much. Let me assure you that we are working very hard to see what it is that we can do with television programing because it is just—I mean, the stuff that we see on television is not what we want our kids to see nor the kind of people to follow as role models. Not in total.

There is nothing wrong with comedic programing, but in the balance, there is not enough. They took "Captain Kangaroo" off of CBS, and thank God CBS was so kind to keep it on as long as they could, but they couldn't compete with the news programs on the other networks. Because ABC and NBC would not provide similar programing, CBS had to finally take it off the air, at least at the time.

So we are working on that. I understand that there is something going on. The only statement I would like to make, and I apologize

to the chairperson for my imposing, but the only other thing I would like to say is that in the scheme of all that we are talking about in saving our young people, we are talking about saving our future. Television is the most powerful medium in the history of the world and it impresses people.

As you were saying, you know, "Facts of Life" is shown all over the world now. I was in Zimbabwe and I was wearing a cowboy hat—I happen to be from Texas and I am proud of it—I am macho like people from Texas—I try not to be too chauvinistic most of the time, but I wear a cowboy hat.

The people had seen "Dallas" in Zimbabwe and they were wondering, how could I be from Texas and be black? In Zimbabwe, they are asking that because there are no black people in "Dallas." So television is impressing the minds of people all over the world.

If they don't see shows like "Facts of Life" or if they see Mr. T syndicated all over the world, then they think that that is what black people are like. The future of our country and this world is dependent, on that technology called television. If we don't develop some constructive and positive programing, then young people—Kim's age and younger—are going to be impressed that all they can be is a Mr. T or George Jefferson, if you will, and there are not going to be any Kim Fields around and "Facts of Life."

Thank you, Madam Chairperson.

Mrs. BOGGS. Thank you.

Mr. Wolf, the most patient of men.

Mr. WOLF. Thank you very much, Madam Chairman.

I just want to thank the panel and Mrs. Fields, too. I have only been here for 3 years and this is, I believe, one of the most important hearings I have attended. I was watching the cameras as you spoke, and not all the TV cameras were on. The ABC channel—I am not sure if it was on, but I know a number of them were not. I appreciate the fact that you are in this business and are willing to be so candid, and not in a critical way, but I think in a constructive way.

I have five children. The eldest is a boy 19 and four daughters, the youngest age 10. First, Kim, I believe you have been extremely courageous. I don't think I would have ever dared to come before a local city council when I was 21 years old, and for you to come up here at 14, I think you deserve a lot of credit.

I don't have—a lot of questions, but there is one I'd like to ask. It seems that both of you, in your testimony, dealt more with the question of self-esteem or maybe lack of self-esteem. Kim addressed it from the child's viewpoint, about the need to have parents and older people listen, but do either of you have any recommendations to bring this about?

What can we do to help our teenagers, our young people, feel better about themselves and improve their self-esteem? Is there any general comment that either of you would want to make?

Ms. LIPSITZ. You are asking a very large question, but let me say that when you scratch beneath any of the disastrous statistics that we have, whether it be suicide, drug abuse, pregnancy, any of the statistics that show young people taking terrible risks with their own lives and the lives of others, including crime, right underneath is constantly the issue of low self-esteem.

The issue of self-esteem is not just something that we should be concerned about if we want to reduce the suicide rate or if we want to reduce the teenage pregnancy rate. It is something that we have to be concerned with across the board. One of the ways to enhance adolescent's self-esteem, one is to give them a great deal of information about what is normal that is going on inside them, because many of them never get that information, nor do their parents have appropriate expectations about what is normal in adolescence.

Another is to give young people as many diverse opportunities to achieve as possible, instead of the very limited opportunities of athletics and academics that we usually give to them.

A third is to give as much adult recognition for their efforts as we possibly can, and a fourth—and this gets us back to the media and to hearings like this—a fourth is to present young people as who they really are because more than 80 percent of these young people are coping remarkably well through a time of the greatest change and stress that is known in human life, in normal adolescent development.

Yet the images that they get of themselves from most adults, and especially from the media, are very negative images of being irresponsible, either with silly, trivial problems that can be resolved within 24 minutes plus two commercials, or assaultive thugs who need to be put away.

There is no middle ground where we see very responsible adolescents acting very responsibly.

Mr. WOLF. OK. Do you, Kim, want to say something?

Ms. FIELDS. I would just like to comment that I appreciate the way everyone opened up their questions. It was basically asking, "What can we do?" and I think the young people really appreciate hearing that and need to hear that statement a lot more.

Mr. WOLF. You have so much wisdom. I would not want you living in my congressional district, if you decided to run for Congress someday in the future. [Laughter.]

You are on the ball. I don't know who your Congressman is, or Congresswoman, but they better be careful of you. [Laughter.]

Again, thank you very much. I appreciate it.

Mrs. BOGGS. Mr. Levin.

Mr. LEVIN. To Kim Fields, first of all, I want to say I am ashamed; I have never seen "The Facts of Life."

Mrs. BOGGS. Do you watch "Dynasty?" [Laughter.]

Mr. LEVIN. "The Facts of Life" were in quotes.

With that confession, let me just, if I might, ask a question of Dr. Lipsitz. One of the concerns I have about your testimony is that I think people may read it very differently. I think there is tendency for all of us to take our predetermined perspective and apply it to testimony, so let me ask you if you can knit it together in summary.

Because, for example, you say at one point the incidence of most negative social indicators among adolescents is horizontal or declining. Then later on—that is on page 4, I guess, of your more summary document—on page 8, you say, "I believe we are witnessing a trend toward the increasing solitude of middle-class youth. Instead of hearing numerous calls for social attentiveness to this issue, we are throwing the responsibility back onto young people." Then on

page 9, "Today, the voices recalling us to a former commitment are few and, ironically, no longer powerful." Then, later on, you refer to cuts in title XX funds.

How do you put these together, these varying trends and varying attitudes toward looking to the self and looking to society? Because I think people are going to read your testimony with quite different conclusions. Or at least, they could, in terms of urgency, in terms of how we respond.

Ms. LIPSITZ. I worried a great deal about that, and I realized that it was a double-edged sword. Let me tell you why I made the decision that I made.

The fact is that some of the most serious indicators of distress and alienation are going down. I think young people need to hear that. I think that parents need to hear that. I think we have to acknowledge the fact that any time the size of the youth population goes down in relation to the rest of the population, these statistics tend to go down in and of themselves.

But we also need to acknowledge that we put a tremendous effort in talent and programs and money into making these statistics go down. I think that every once in a while, we need to step back, pat ourselves on the back and say that we did something right, and then turn around and look at how much in jeopardy these very programs are and say to ourselves, "Do we then want to reap the bitter harvest again of seeing these statistics start going up?"

That is the first thing. I worried a great deal about exactly the question that you are asking me, and yet I think that it would be foolhardy not to acknowledge that we have done something right. Otherwise, you could be sitting there and saying to me, "Dr. Lipsitz, we threw all this money at these problems and what did we get?" Well, we did get something.

On the other hand, the numbers are not heartening; they are very disheartening and that is in the lengthier testimony. There are still—whether we have a youth crisis or not, we have youth in crisis, and we have large numbers of youth in crisis. For us to stop our efforts now would be tragic.

That was a real worry that I had, but I came out, and I think Kim would probably applaud this, I came out on the side of the adolescents, saying "They must learn from us that they are making some wise decisions."

They must learn from us that we understand that much younger than you and I needed to, they are daily making decisions, daily, about drugs, alcohol, sex, driving too fast in cars, and so forth, that you and I made at much later—I assume you, I am making assumptions about you—that I made much, much later in my life, 12-, 13-, 14-year-olds are daily under this kind of pressure.

We need to acknowledge that many of them have the strength to make life enhancing, rather than life-destructive decisions. We also need to acknowledge, and please note that not only did Kim have the symbolic touch on the back from her mother, she had the real hand going on her back. There are many, many Kims in this country who do not have either the symbolic or the real hand from a parent on their back.

That means that the rest of us as adults must start reasserting our responsibility, reassuming our responsibility for these youngsters.

Mr. LEVIN. Thank you.

Ms. LIPSITZ. Does that tie it together better?

Mr. LEVIN. I think very well.

Mrs. BOGGS. Have you finished, Mr. Levin?

Mr. LEVIN. Yes.

Mrs. BOGGS. Thank you very very much. We are very fortunate on this task force, and also in the Congress, that we have someone who has come to the Congress with a broad base in community activities and philanthropic cultural activities. I would like to invite her now to ask questions.

Ms. Johnson.

Mrs. JOHNSON. Thank you very much, Congresswoman Boggs.

I want to thank you both for your testimony today. It certainly has been very interesting, and very informative Kim, what you are actually doing—the value of that really cannot be overestimated because examples of responsiveness, of caring, of the right kind of relationships, of being willing to talk about the seriousness of the problems and the real pains is certainly without question part of the solution.

I concur with the comments that my colleague, Mr. Leland, made earlier about his deep concern about the image that television is presenting to our young people of what life ought to be like. It presents practically no image of healthy, loving, caring relationships, of working through problems, of finding solutions, of having loyalty, courage, hope, faith, any of those things. That is very distressing.

I also appreciate Dr. Lipsitz' serious consideration of the issue of isolation that you brought out. I think that isolation, combined with normal self-esteem problems, which are aggravated by decisionmaking at an early age on very serious and very difficult issues, are all part of why we need to think so seriously about what we are doing in our society and perhaps how we are spending what little Federal money we have and examining what the Federal role is.

One of the things that really disturbs me keenly that I know you have no answer to, but I would like to have your thoughts on, is a problem that I have seen over and over again as we have sought the very kinds of solutions that you have proposed here.

I have been involved with libraries, trying to get teenagers involved, with peer counseling programs in our family guidance clinic, in work opportunities programs where young people were given the opportunity to help, to assist, to befriend, to companion seniors, and it does work wonderfully when you can do it. But one of the really serious issues is how do we get young people involved?

What is wrong with our schools, possibly, our homes, that no matter how much money we put in, no matter how many good programs we get, we still face the problem of children going home after school and watching soap operas rather than coming to participate in these activities.

I mean, I have talked to the coaches in the high school where my youngest daughter just graduated and I have talked to the music

directors. They can't get participation. Kids won't commit themselves and it is a vicious circle. Their own personal lack of self-esteem doesn't allow them to devote themselves to activities through which they would make a difference, both to themselves and to others that—whole cycle. Why is it that our education system is somehow not allowing our young people to feel their own sense of growth or to understand what it means to get involved, or what is in it for them to get either deeply involved in athletics, in civil activities, in church or all those things that used to be there, and sometimes are there and have an enrollment of 5 when they could handle 25.

You know, behind what you are saying is that this problem of participation and almost a self-imposed isolation, is a withdrawal from participation, even in learning, in school. It strikes me that one of the challenges is to make the school experience more fully developing and more engaging early on. I think maybe part of the challenge is to deal with what does it mean to have your parents separate, what does it mean for you to grow up in a different kind of family, maybe begin talking about those things in kindergarten and first grade and second grade.

How are we ever going to ready young people to participate in the very things that you know will help them make better decisions?

I guess I am not making myself very clear.

Mrs. FIELDS. May I just say something?

Mrs. JOHNSON. Yes.

Mrs. FIELDS. On a very gut-level feeling about this, I think—because I was going to ask Chairperson Boggs could I say one thing about it—spending too much time in the paperwork, and this is a town where you know about paperwork, but one of the things I think might help what you just talked about is that is where we are not using the children resource.

Mrs. BOGGS. That is right.

Mrs. FIELDS. If you get a bunch of kids in a school—each school knows who the power people are in their schools. That is not work you need to worry about, but if it is available that somebody gets the formula, let's bring in those power people, those influential kids that are in those schools, let's get them excited about the program. It is the outreach of kids to kids that is going to make that successful.

You can have all the dynamic leadership you want, but if little Joe—if little Joe says, "Come on, Kim, I want you to come and do this; guess what we are doing, we are doing this and that over here."

That is a lot more effective than all of these forms and papers that nobody really gives a darn about when you are sitting up there in that school with the drug problem going on all around you. But they will go out and they will look at a drama program that has something good going on, that some of the peers themselves are putting together.

That is going to be where you had better start really tuning into that. That is the one thing in that testimony that really got to me, was that kids are a valuable asset and a resource that are not being used, and every time you ever see some person that you give

a lot of credit to for working so well with kids, and that is a dynamic person with young-person groups, it is always somebody that is not standing there in the limelight himself, but like this man here, letting the kids do it. That is what pulls those kids together.

That is what would make what you said happen.

Mrs. BOGGS. That is an excellent point, excellent point.

Dr. Lipsitz, would you respond?

Ms. LIPSITZ. Yes. First of all, I would like to say that adolescents don't grow up in America; they grow in particular communities. What you may face in one particular community may not be the same as what is being faced in another community. The Oakland, Calif., study showed that kids were amazing users of public services like the libraries, parks, recreation departments, and so forth.

The Montgomery County study shows that youngsters are going home, but about 88 percent of the parents are just as happy to have them staying at home—and that is upper middle-class white parents—and so I have a problem generalizing across the board. However, having said that, definitely the youngsters have to be engaged in the planning for themselves. Most adults say, "We planned a wonderful program and then the kids didn't come." Right there is the key to what went wrong.

Youngsters vote with their feet in after-school programs. They don't have to go. You can kill yourself to try to get them there and they don't have to go. In some parts of the country, parents won't let them go because the safety issues are so extraordinary that the kids cannot make it safely from school to the publicly supported after-school program because it is too dangerous and there is no bus to take them from the school to that after-school program.

So the parents will say, "Go home, lock the door, turn on the television set so somebody will know that there is somebody home and there won't be a break-in"—we haven't pointed out the fact that having the television set on is a safety factor in some houses in this country—"and call me at work."

There is a tremendous amount of babysitting going on and downtime going on in the after-school hours where the parents are babysitting by telephone to make sure that the kid is where that person—the kid really is supposed to be. A lot of programs will not be accountable to parents. They will not take attendance and say, "Yes, your child is here."

Well, if I don't know that my 12- or 13- or 14-year-old is where he is supposed to be, I am going to tell him to go home and lock the door. That is another barrier.

The fee schedules have become tremendous barriers in many communities. As with the cuts in public funds, the programs have had to go onto fee schedules, but in terms just of what you are describing, adolescent development itself is a barrier. Adolescents do not want to go from one situation in which they are deeply, deeply, tightly controlled, the schools, into another situation in which they are equally, if not more so, deeply controlled.

I think if we could get to hear from some of the programs and the people who are waiting to testify, we will hear how they have very successfully brought youngsters in and have waiting lists and if they had more staff and more funds, there wouldn't be waiting

lists of hundreds of kids trying to get into those programs the way they have.

Mrs. JOHNSON. Thank you.

Mrs. BOGGS. We are so pleased that you have been with us and we are sorry we have kept you so long. We are also sorry we have kept witnesses waiting for such a long time. Now that we have gotten the Californians all the way up to almost arising time in California, we thank you very much and we would like to have the next panel come.

We thank all of you very much for being so patient. We have a very exciting panel before us now. I will present all of you en bloc and then start with Ms. DeFiglia if we may.

We have Ms. DiFiglia, who has the finest title of all of our witnesses; she is a parent from Plano, Tex. Judie Smith, who is the program director of the Suicide and Crisis Center, Dallas, Tex.; Eva Deykin, who is assistant professor of Maternal and Child Health, School of Public Health at Harvard University; and Dr. Mary Giffin, who has recently produced this beautiful book, "A Cry for Help," is the medical director of the Irene Josselyn Clinic, Northfield, Ill.

We are very, very honored to have each of you here and, Ms. DiFiglia, we especially are honored to have you and thank you for your willingness to share with us your feelings and your tragedy.

I introduce Ms. DiFiglia.

STATEMENT OF ELAINE DiFIGLIA, PARENT, PLANO, TEX.

Ms. DIFIGLIA. Madam Chairman, committee members, news media, and friends, being invited to come to this hearing by Mrs. Lindy Boggs and Judie Smith, of the Dallas Suicide and Crisis Center, I come before this committee to share with you my experiences as a parent who has lost a child due to suicide.

I am Elaine DiFiglia from Plano, Tex., a suburb of Dallas, where I live with my husband, Charlie, and my 16-year-old son, Chuck. Two months ago, our oldest son, Scott, who was 18 years old, decided to take his own life because he felt he could no longer live with the pain that was inside of him.

At this time, I would like to give you a little bit of an insight into Scott. Scott was a sensitive, intelligent, well-mannered, ambitious 18-year-old. Scott loved the all-American sport of baseball. He played soccer and baseball since he was in kindergarten and was on a local softball team.

He also loved to fish and hunt, which he did quite often with his dad and his brother, Chuck. Scott loved to collect things. He had a fabulous baseball card collection, a match cover collection, a collection of hats and caps, as well as a collection of fishing pictures covering a wall in his bedroom.

He loved to keep records on everything. We have found notebooks in his drawers where he kept records of his money earned, where he spent it, and what he spent it on. He kept a notebook on his fishing: Where he fished, when, with whom, what he caught and what type of bait he used.

He kept track of all of his record cassettes and tapes, how much they cost and where he bought them. He also had a fantastic collection of letters from his girlfriend.

Scott was a caring person; he was a normal teenager with normal adolescent problems. We were able to communicate, but Scott kept a lot of his feelings inside and never wanted to burden anyone with his problems. He always felt he could handle them himself.

My husband and I feel that we have provided a nice comfortable home for Scott, with lots of love and concern. We do live in a nice neighborhood that is filled with beautiful people. We have the best of schools with many different programs and opportunities, many different organized sports activities throughout the community, and we have worried about our children day and night, like all other normal parents.

We do live in a success-oriented community and there are a lot of children there struggling to deal with this striving for success, but there are also a lot of teenagers who are thriving and achieving high goals as a result of living in this type of community.

We feel our children today do have a lot of pressures put on them. There is the old peer pressure, pressure of drugs and alcohol, pressures of succeeding and getting good grades, just like all kids throughout the country. Sometimes I feel our children have more pressures than we do.

For instance, a teenager in our community is stopped and given a ticket for racing at 22 miles per hour in a school zone where there is 20 miles per hour speed limit. If this was an adult, it would be either overlooked or the ticket would indicate the driver was speeding, rather than racing.

A teenager will be picked up for possession of alcohol, but how often is it looked into, who sold this alcohol to the minor? The same thing goes for drugs. We need to stop teaching our children this double standard of living. We are examples for our children and they have only us to copy and to follow in our footsteps.

Charlie and I feel we have been the best parents we could have been to Scott. We were the parents we knew how to be. None of us ever have any training on how to be parents. We can only learn from our parents and most of us raise our children as we were raised and always try to make it easier and more comfortable for them.

Scott was getting ready to leave home for college. He was to leave the following weekend to attend a college of his choice to learn a technical trade. He enjoyed creating things and working with his hands. He was going to live in a house off campus with his best friend of 5 years and was extremely excited about it. He had been making plans for the move all summer.

Even up until the last few hours before he shot himself, he called me at the office and told me of his plans for the weekend of moving all his belongings to school.

Scott had a great summer. He worked with a man who had a big influence on his life for the past 3 years, and he had a great junior and senior year in his high school that was filled with a lot of friends.

So why, a child who had so much going for him, did he choose to end his life? In the note he left us, he said he could no longer go on living with the pain he had inside him. He and his girlfriend had been off and on with their relationship for several months. Scott felt he had ruined all of their hopes and dreams. He didn't like himself for all the trouble he had caused both of them.

Scott couldn't tell us about this pain. We had no idea he was suffering. He showed us no signs of depression. I thought I knew our son so well. I, his mother; I who was so close to him couldn't even help him because I didn't know he was hurting.

This committee wants to know what we could have done to have prevented this tragedy. At this point in time, I don't know if I can fully answer that question. I don't know if we had to do it all over again what we would change, but I can tell you this: My own personal reason for coming here to Washington is to give myself and my husband and my son some comfort in our grief by trying to help other parents and troubled teenagers.

I do not want my son's death to be in vain. Some good has to come from this tragedy.

One of the things that has helped us the most is talking to other parents who have lost a child by suicide. Suicide is so hard for anyone to accept or even talk about. If a child dies by an accident or an illness, even though it isn't any easier to bear, you at least have a reason. But suicide is so hard to accept. There are no direct answers. The person who has the answers is dead and those answers are buried.

The survivors of suicide need someone to reach out to in order to ease their pain and to help them to understand suicide. We have been contacted by a local support group, compassionate friends and by the Dallas Suicide Crisis Center, the latter of which is offering an 8-week course, which is a support group, starting again on November the 2d. This program has been strongly recommended to us by other parents who have gone through the course.

Our local schools are offering classes on stress; parents are meeting almost weekly to talk about adolescent problems. There are about 35 parents who are being trained to help with the 24-hour phone crisis line that will open in our community in December.

The students at our local high school have been fantastic. They have formed their own group, called BIONIC, which stands for "Believe It or Not, I Care," and one of our school counselors formed a SWT group, which stands for "Students Working Together."

There are a few things I can suggest to help prevent suicide and the first of these is communication. I know you all hear this day in and day out, but communication is so important between parents and children. Communicate with your kids; talk to them; listen to them. By "listen," I mean listen to their words; listen to their actions; listen to them by watching their moods. Try to hear what they are telling you. Believe me, if there is no talk, no communication, then there are big problems.

We have had so many teenagers come to us in the past two months and say to us, "I can't talk to my parents; they don't understand me. My parents can't talk to me." Do you know what I tell these kids? I tell them, "You go home tonight and you talk to your Mom and Dad and you tell them the one thing you want them

to know if you knew they wouldn't be here tomorrow or forever more."

And you parents, go home and tell your children what you would want them to know if you knew you would never have another chance to tell them and believe me, this would start some communication.

I also suggest we talk about suicide. Ask our kids how they feel about it; if they have ever considered it; if they realize how final it is; and if they realize all the hurt and heartache and pain it leaves behind.

When we talk about suicide, so many people think of kids on drugs or alcohol or kids who have been in trouble with the law, but I am here to tell you differently. It can happen in the best and happiest of homes. It can happen to you.

We need to make our children aware of the vital signs of suicide so they know for themselves and they can detect the signs in their friends and seek help.

We need to convince our children that problems do arise all the time, but there really isn't anything that can't be worked out together. So many teenagers that experience such deep inside pain don't realize it is only temporary, things can get better and they will get better with time. Our children need to be told that life is a gift that needs to be treasured.

There isn't a day or an hour that goes by that I don't wish I could talk to Scott, to laugh with him again, to hug him and to tell him that I love him, to let him know that we care.

My son chose to end his life and hopefully with time, God will help us to understand why it had to happen.

Mrs. BOGGS. Thank you so much for your bravery, for your wonderful contribution to us, and to the understanding of others. You help all of us, particularly parents and young people.

Great good will, indeed, come of your tragedy because of your own bravery and sharing. Thank you so very much.

We thought that we would go through the panel of witnesses and then be able to have questions for all of us as we go by. Now I would like to please introduce Judie Smith, who is the program director of the Dallas, Tex., Suicide and Crisis Center, to which Ms. DiFiglia referred.

Ms. Smith.

[Prepared statement of Elaine DiFiglia follows:]

PREPARED STATEMENT OF ELAINE DIFIGLIA, PLANO, TEX.

Being invited to come to this hearing by Mrs. Lindy Boggs and the Dallas Suicide and Crisis Center, I come before this committee to share with you my experience as a parent who has lost a child due to suicide.

I am Elaine DiFiglia from Plano, Texas, a suburb of Dallas where I live with my husband, Charlie and 16 year old son, Chuck. Two months ago our oldest son, Scott, who was 18 years old, decided to take his own life because he felt he could no longer live with the pain he had inside him.

Scott was a sensitive, intelligent, well-mannered, ambitious 18 year old. Scott loved baseball, the all American sport, played soccer and baseball since he was in kindergarten and was on a local softball team. He loved to fish and hunt, which he did a lot of with his Dad and brother, Chuck.

Scott loved to collect things. He had a fabulous baseball card collection, a match cover collection, he collected hats and caps and has a collection of fishing pictures covering a wall in his bedroom. He loved to keep records on everything. We have

found notebooks in his drawers where he kept records of his money earned, how he spent it and where. He kept a notebook on his fishing, where he fished, when, with whom, what he caught, and what type of bait he used. He kept track of all his record cassettes and tapes, how much they cost and where he bought them. Also had a fantastic collection of letters from his girlfriend.

Scott was a caring person—he was a normal teenager with normal adolescent problems. We were able to communicate but Scott kept a lot of his feelings inside and never wanted to burden anyone with his problems. He always felt he could handle them himself. My husband and I provided a nice comfortable home for Scott with lots of love and concern. We live in a nice neighborhood filled with beautiful people, we have the best of schools with many different programs and opportunities, many different organized sports activities throughout the community and we've worried about our kids day and night like all normal parents. We do live in a success oriented community and there are a lot of children struggling trying to deal with this striving for success, but there are a lot of teenagers who are thriving and achieving high goals as a result of living in this type of community.

Our children today do have a lot of pressures put on them. There's the old peer pressure, pressure of drugs and alcohol, pressures of succeeding and getting good grades—just like all other kids throughout the country. Sometimes I feel our children have many more pressures than we do. For instances—a kid in our community is stopped and given a ticket going 22 mph in a school zone where there is a 20 mph speed limit. If this was an adult, it would be overlooked. A teenager will be picked up with possession of alcohol, but how often is it looked into who sold this liquor to the minor. The same goes for drugs. We need to stop teaching our children this double standard of living. We are examples for our children and they have only us to copy and to follow in our footsteps.

Charlie and I feel we were the best parents we could've been to Scott. We were the best parents we knew how to be. None of us ever have any training on how to be a parent. We can only learn from our parents and most of us raise our children as we were raised and always try to make it easier and more comfortable then we had it.

Scott was getting ready to leave home for college. He was to leave the following weekend to attend a college of his choice to learn a technical trade, he enjoyed creating things and working with his hands. He was going to live in a house off campus with a best friend of five years and was extremely excited about it. He had been making plans for the move all summer, even up to the last few hours before he shot himself he called me at work and told me of his plans for the weekend of moving all his belongings to school. Scott had a great summer, worked with a man who had a big influence on his life for the past three years, had a great junior and senior year and had a lot of friends. So why, a child who had everything going for him, why did he choose to end his life? In the note he left us he said he could no longer go on living with the pain he had inside him. He and his girlfriend had been on and off with their relationship for several months. He felt he had ruined all their hopes and dreams, he didn't like himself for all the trouble he had caused both of them.

Scott couldn't tell us about this pain—we had no idea he was suffering, he showed us no signs of depression. I thought I knew my son so well, I, his mother, I who was so close to him—I couldn't even help him because I didn't know he was hurting. This committee wants to know what we feel could have prevented this tragedy. At this point in time I don't know if I can fully answer that question. I don't know if we had to do it all over again what we would change.

But I can tell you this—my own personal reason for coming here to Washington is to give myself and my husband and son some comfort in our grief by trying to help other parents and troubled teenagers. I do not want my son's death to be in vain. Some good *has* to come out of this tragedy.

One of the things that has helped us the most is talking to other parents who have lost a child by suicide. Suicide is so hard for anyone to accept or to even talk about. If a child dies by an accident or an illness, although it's not any easier to bear, you at least have a reason. But suicide is so hard to accept—there are no direct answers—the person who has the answers is dead and the answers are buried. The survivors of suicide need someone to reach out to in order to ease their pain and to help them to understand suicide. We have been contacted by a local support group, Compassionate Friends, and almost immediately by the Dallas Suicide And Crisis Center, which is offering an 8 week therapy course starting again on November 2nd. This program has been strongly recommended to us by other parents who have gone through the course.

Our local schools are offering classes on stress, parents are meeting almost weekly to talk about adolescent problems. There are about 35 parents who are being

trained to help with a 24-hour phone crisis line that will open in our community in December. Students at our local high school have formed their own group, BIONIC (Believe It Or Not, I Care) and one of our school counselors formed a SWAT Club (Students Working Together).

There are a few things I can suggest to help prevent suicide—1st is Communication. I know you all hear this day in and day out, but communication is so important between children and parents. Communicate with your kids—talk to them—listen to them. By listen, I mean listen to their words, their actions, listen to them by watching their moods. Try to hear what they're telling you. Believe me if there is no talking between you and your children, there are big problems.

I have had so many teenagers come to me in the past two months and say "I can't talk to my parents, they don't understand. My parent can't talk to me." Do you know what I tell these kids? I tell them—before you go to bed tonight I want you to tell your Mom and Dad the one thing you'd want them to know if you knew they wouldn't be here tomorrow or for ever more—and you, parents, tell your children the one thing you would want them to know if you knew you'd never have another chance to tell them again. That will start some communication!

I also suggest we talk about suicide. Ask our kids how they feel about it, if they've ever considered it, if they realize how final it is, and if they realize all the heartache and pain it leaves behind. When we talk about suicide so many people think of kids on drugs or alcohol and kids who've been in trouble with the law, but I'm here to tell you differently. It can happen in the best and happiest of homes. It can happen to you! We need to make our children aware of the vital signs of suicide so they know for themsleves and they can detect the signs in their friends and seek help. We need to convince our children that problems do arise all the time, but there really isn't anything that can't be worked out together. So many teenagers that experience such deep inside pain don't realize it's only temporary, things can get better and they will get better with time. Our children need to be told that life is a gift and it needs to be treasured.

There isn't a day or an hour that goes by that I don't wish I could talk to Scott, to laugh with him again, to hug and tell him that I love him and let him know we care. My son chose to end his life and hopefully with time God will help to understand.

STATEMENT OF JUDIE SMITH, PROGRAM DIRECTOR, DALLAS, TEX., SUICIDE AND CRISIS CENTER

Ms. SMITH. Mrs. Boggs and members of the committee, thank you for the opportunity to describe the recent trends in adolescent suicide and how the Dallas community is facing the problem through the efforts of the Suicide and Crisis Center.

The incidence of suicide among adolescents and young people is increasing at a very alarming rate. Since the 1950's, this rate has tripled. Men comprise three-fourths of all suicides, and young men ages 15 to 19 are killing themselves at a rate that is 400 percent higher than three decades ago. In the first copy of my report that you have there is a typographical error. It says 40 percent, which is impressive enough, but 400 percent is truly horrendous.

Suicide is the third leading cause of death for this age group. For the first time in history, more young people are committing suicide more frequently than the elderly. Nineteen-and-a-half percent of all suicides are under the age of of 25. Close to 6,000 young people choose to end their lives every year.

The Dallas community is particularly vulnerable to suicide. We have the tragic position of having the second highest rate of adolescent suicide in the Nation. We can expect one suicide every other week under the age of 20. The Dallas suburb of Plano, where Mrs. DiFiglia is from, had six suicides in one high school within a 6-month period. What happened in Plano is not unique. Arlington, another suburb of Dallas, had six teenage suicides within a 2-month period 2 years ago. For every completed suicide there are

nine attempts that come to the attention of the authorities. It is estimated that this is an extremely low figure, and that at least 50 young people attempt suicide for every known completion.

Why Plano? Why Arlington? These are affluent, beautiful communities. What contributes to the dynamics that led so many young people to choose to die? The failing of the family as an institution is a major cause of the increased rate of suicide. The Dallas area has one of the highest rates of divorce in the Nation. Research shows that there is a high relationship between the divorce rate, single parent households, and the suicide rate among 15- to 24-year-olds.

Plano is a very fast-growing area. In 1970 it had a population of under 10,000. In 1980, it had grown to over 80,000. With growth comes change. With change comes stress. One of every ten students will be new to the high school this year. When families relocate they leave behind friends that are so important in times of crisis. Our society has become so mobile that families are not as likely as they were a generation ago to put down roots and to weave that network of extended family members to show love and support to the children.

Another factor that is related to the increase in adolescent suicide is the tremendous emphasis on success in an upwardly mobile society and in communities such as Plano. The children set high expectations for themselves with overt and covert messages from their parents. High goals of being accepted into a prestigious college, becoming the star football player, being chosen a cheerleader or homecoming queen, or making straight A's may be an unrealistic burden for these teenagers who are achievement oriented. Suicidal individuals have a feeling of worthlessness. Low self-esteem translates into worthlessness.

The fear that suicide among adolescents is reaching epidemic proportions has stimulated the Dallas community to address the issue of suicide in an effort to bring help to these young people who are experiencing such despair and are feeling so helpless and so hopeless that they no longer wish to live.

The Dallas Suicide and Crisis Center, accredited by the American Association of Suicidology, was established in 1969 by mental health professionals who recognized the need for counselors to be readily available for people who are in a crisis. The center is funded solely by donations. One-third of these donations come from private individuals; one-third come from businesses and corporations; and one-third come from foundations. The crisis counselors are highly trained and highly skilled paraprofessionals. They volunteer their time and, through their efforts, the agency has been able to expand its services from the original 24 hour hotline to support groups, outreach teams, public speaking, research, and inservice training for other professional agencies. Each year the center sponsors an adolescent symposia which serves as a forum for an exchange of ideas on adolescent problems by national authorities in the field. Recognizing the fact that if we are going to have an impact on reducing the rate of adolescent suicide, we must use our expertise in educating parents, teachers, counselors, and the teenagers themselves to be aware of suicidal warning signs and to teach them how to communicate, how to respond to someone who

is contemplating suicide. Teenagers need to learn how to meet life events, to develop coping skills, and use other alternatives instead of suicide.

The Dallas public schools has mandated that crisis intervention be taught in the classroom. The Suicide and Crisis Center has developed a curriculum for use in the health classes' mental health unit. Every student who graduates is required to take a course in health. The curriculum is designed to be used in five different lesson plans. With each lesson the teacher is given background information, the basic concept of the lesson, and exercises to stimulate discussion. The objectives are to help the students to: One, become knowledgeable about the problem of suicide by replacing misconceptions and misinformation with facts; two, be aware of their own attitudes toward suicide; three, be able to identify individuals who are at risk for suicide; four, learn how to intervene when someone is in a crisis by acquiring good listening and communication skills; and finally, five, learn where to turn to for help.

In November we are offering 6-hour crisis intervention skills training workshops for every elementary and secondary school counselor in the Dallas school district. The emphasis will be on assessing suicidal risk, recognizing suicidal signs, responsible thinking and communicating, conveying empathy and respect, and we will teach the crisis intervention model. In short, each counselor will be introduced to the skills used by crisis counselors who work on the telephone crisis line.

We have also trained teenagers to become crisis counselors. In response to a questionnaire in San Mateo County, California, 93 percent of the high school students stated they would turn to a friend before turning to their parents, teacher or minister when they had a problem. Peer counseling is the logical intervention strategy. Our teenage crisis counselors work on the crisis line and we are extremely pleased with their skills and effectiveness.

In response to the Plano crisis, the Dallas Suicide and Crisis Center has taken several approaches. After the first suicide last February, we were requested by a police social worker to meet with the friends of the young man who committed suicide. We facilitated a grief group to allow them to express their anguish and to speak openly about their fears and anger. Our counselors also made numerous presentations to school, church, and civic groups since this first suicide. They presented themselves as knowledgeable and skilled in crisis intervention and invited those in the audience to use the services of the Crisis Center. Our calls have increased 20 percent since the beginning of the Plano crisis.

The Plano schools invited us to lead a stress workshop for the teachers' inservice training. We helped them understand how stress may lead to a crisis and how they can effectively intervene if a crisis occurs.

Following the last teenage suicide, we were asked to provide workshops for the Plano community. We met on six separate evenings with parents who wanted to know more about suicide and what they could do to help their children. We taught them how to recognize suicidal warning signs and how to communicate on a feeling level, to accept and respect their children's problems. More workshops for teaching communication skills are planned.

In conjunction with a local radio station, KAFM/KAAM, a project has been developed using their local radio personalities and nationally known stars for programing, assemblies, public service announcements, and fundraising. This project has been offered free of charge to the center. An undertaking of this magnitude would ordinarily be beyond the means of our nonprofit agency.

In spite of this aggressive programing, we fully expect that some day another young person will commit suicide in Plano. The anger and the fear will again be prevalent in a community that has high hopes for its young people and itself. More can be done to prevent these tragic suicides.

The Suicide and Crisis Center hopes to hire a youth director who will be able to train peer counselors in every school, to develop a crisis line for teenagers which is staffed by teenagers, to offer support groups for adolescent attempters, and to facilitate a survivors of suicide program for teenagers. Research is necessary to better understand the complicated dynamics of suicide and the influence of society on these dynamics. As funds become available, the center plans to undertake vigorous research projects addressing suicide prevention, intervention, and postvention.

The task of reducing the teenage suidice rate is enormous, but it is not insurmountable. The Dallas Suicide and Crisis Center and the American Association of Suicidology are dedicated to this effort.

Mrs. Boggs. Thank you very much, Miss Smith, for your very splendid testimony.

[Prepared statement of Judie Smith follows:]

Prepared Statement of Judie Smith, Program Director, Dallas, Tex., Suicide and Crisis Center

SUICIDE TRENDS

The incidence of suicide among adolescents and young people is increasing at an alarming rate. Since the 1950's this rate has tripled. Men comprise three-fourths of all suicides and young men 15–19 years old are killing themselves at a rate that is 400 percent higher than three decades ago. For the first time in our history more young people are committing suicide more frequently than the elderly. Nineteen and one-half percent of all suicides are under the age of 25. Close to 6,000 young people choose to end their lives every year.

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INFLUENCING FACTORS

Why Plano? Why Arlington? These are affluent, beautiful communities. What contributes to the dynamics that lead so many young people to choose to die? The failing of the family as an institution is a major cause of the increased rate of suicide. The Dallas area has one of the highest rate of divorce in the nation. Research shows that there is a high relationship between the divorce rate, single parent households and the suicide rate among 15–24 years olds.

Plano is a fast growing area. In 1970 it had a population of 10,000. In 1980 it had grown to over 80,000. With growth comes change. With change comes stress. One of every ten students will be new to the high school this year. When families relocate

they leave behind friends that are so important in times of crisis. Our society has become so mobile that families are not as likely as they were a generation ago to put down roots and weave a network of "extended family" members to show love and support to the children.

Another factor that is related to the increase in adolescent suicide is the tremendous emphasis on success in an upwardly mobile society and in communities such as Plano. The children set high expectations for themselves with overt and covert messages from their parents. High goals of being accepted into a prestigious college, becoming the star football player, being chosen a cheerleader or homecoming queen, of making striaght A's may be an unrealistic burden for these teenagers who are achievement oriented. Accomplishments and success, or failure, directly influence self-esteem. Suicidal individuals have a feeling of worthlessness. "Low self-esteem" translates into "worthlessness."

FACING THE PROBLEM

The fear that suicide among adolescents is reaching epidemic proportions has stimulated the Dallas community to address the issue of suicide in an effort to bring help to these young people who are experiencing such despair and are feeling so helpless and hopeless that they no longer wish to live.

The Dallas Suicide and Crisis Center, accredited by the American Association of Suicidology, was established in 1969 by mental health professionals who recognized the need for counselors to be readily available for people who are in a crisis. The Center is funded solely by donations: one-third of these donations come from individuals, one-third from businesses and corporations, and one-third from foundations. The crisis counselors are highly trained and highly skilled paraprofessionals. They volunteer their time and, through their efforts, the agency has been able to expand its services from the original 24-hour hot line to support groups, outreach teams, public speaking, research, and inservice training from other professional agencies. Each year the Center sponsors and Adolescent Symposia which serves as a forum for an exchange of ideas on adolescent problems by national authorities in the field. Recognizing the fact that if we are to have an impact on reducing the rate of adolescent suicide, we must use our expertise in educating parents, teachers, counselors, and the teenagers themselves to be aware of suicidal warning signs and teach them how to communicate, to respond to someone who may be contemplating suicide. Teenagers need to learn how to meet life events, to develop coping skills, and use other alternatives instead of suicide.

The Dallas public schools have mandated that crisis intervention be taught in the classroom. The Suicide and Crisis Center has developed a curriculum for use in the health classes' mental health unit. Every student who graduates is required to take a course in health. The curriculum is designed to be used as five separate lesson plans. With each lesson the teacher is given background information, the basic concept of the lesson, and exercises to stimulate discussion. The objectives are to help the students: (1) become knowledgeable about the problem of suicide by replacing misconceptions and misinformation with facts, (2) be aware of their own attitudes toward suicide, (3) be able to identify individuals who are at risk for suicide, (4) learn how to intervene when someone is in a crisis by acquiring good listening and communication skills, and (5) learn where to turn for help.

In November we are offering six-hour crisis intervention skills training workshops for every elementary and secondary school counselor in the Dallas School District. The emphasis will be on suicidal risk, recognizing suicidal signs, responsible thinking and communicating, conveying empathy and respect, and the "crisis intervention model." In short, each counselor will be introduced to the skills used by crisis counselors who work on the telephone crisis line.

We have also trained teenagers to become crisis counselors. In response to a questionnaire given in California, 93 percent of the high school students stated they would turn to a friend before turning to their parents, teacher, or minister when they had a problem. Peer counseling is the logical intervention strategy. Our teenage crisis counselors work on the crisis line and we are extemely pleased with their skills and effectiveness.

RESPONDING TO PLANO

In response to the Plano crisis, the Dallas Suicide and Crisis Center has taken several approaches. After the first suicide last February, we were requested by a police social worker to meet with the friends of the young man who suicided. We facilitated a grief group to allow them to express their anguish and to speak openly about their fears and anger. Our counselors also made numerous presentations to

school, church, and civic groups since this first suicide. They presented themselves as knowledgeable and skilled in crisis intervention and invited those in the audience to use the services of the Crisis Center. Our calls have increased 20 percent since the beginning of the Plano crisis.

The Plano schools invited us to lead a stress workshop for the teachers (inservice training). We helped them understand how stress may lead to a crisis and how they can effectively intervene if a crisis occurs.

Following the last teenage suicide we were asked to provide workshops for the Plano community. We met on six separate evenings with parents who wanted to know more about suicide and what they could do to help their children. We taught them how to recognize suicidal warning signs and how to communicate on a feeling level, to accept and respect their children's problems. More workshops for teaching communication skills are planned.

In conjunction with a local radio station, KAFM/KAAM, a project has been developed using their local radio personalities and nationally known stars for programing, assemblies, public service announcements, and fund raising. This project is being offered free of charge to the Center. An undertaking of this magnitude would ordinarily be beyond the means of our non-profit agency.

In spite of this aggressive programing, we fully expect that some day another young person will commit suicide in Plano. The anger and fear will again be prevalent in a community that has such high hopes for its young people and itself.

GOALS

There is more that can be done to prevent these tragic suicides. The Suicide and Crisis Center hopes to hire a Youth Director who will be able to train peer counselors in every school, develop a crisis line for teenagers which is staffed by teenagers, offer support groups for adolescent attempters, and facilitate a Survivors of Suicide program for teenagers. Research is necessary to better understand the complicated dynamics of suicide and the influence of society on these dynamics. As funds become available, The Center plans to undertake vigorous research projects addressing suicide prevention, intervention, and postvention.

The task of reducing the teenage suicide rate is enormous but not insurmountable. The Dallas Suicide and Crisis Center and The American Association of Suicidology are dedicated to this effort.

Mrs. BOGGS. Dr. Eva Deykin, would you proceed, please?

STATEMENT OF EVA DEYKIN, ASSISTANT PROFESSOR OF MATERNAL AND CHILD HEALTH, SCHOOL OF PUBLIC HEALTH, HARVARD UNIVERSITY

Dr. DEYKIN. Chairwoman Mrs. Boggs, honorable Members of Congress, ladies and gentlemen, I would like to preface my testimony today on adolescent suicide by sharing with you a brief excerpt from an article published in the Boston Globe on March 23 of this year. The dateline is Edgewater, Md.

Sitting on a blanket of oak leaves in the woods behind her school, Melissa Putney and her 12-year-old cousin finished their picnic lunch and swallowed the last of their wine. Twelve minutes before noon, a tiny white fleck of light appeared far down the railroad tracks. Then, seconds later came the crescendo of engines going 100 miles an hour. Amtrak 141, the Bankers, was right on time.

Melissa ran to the tracks, knelt between the rails and clasped her hands in prayer. Her cousin Pearl tried to stop her, but Melissa had always been bigger and stronger. Melissa Celeste Putney made the sign of the cross.

On March 15, Melissa had walked the 2 miles to school. She and her cousin Pearl slipped out a back door before 11 a.m., walked half a mile across the playing fields to the railroad tracks that carry 52 Amtrak trains past the school every day. They had

brought sandwiches in brown bags and two bottles of wine, according to the Maryland State Police. The two girls ate, drank, and talked, and Melissa wrote the note to her mother, which was later found among her books.

She wrote,

"I am very sorry to put you through all this trouble. I think everything I have to do is done. I drank some wine and took some pills. But before I did all that, I prayed to my Father, God in Heaven. I asked him to forgive me, but I know he won't. I don't blame him for that.

Mom, please don't have a nervous breakdown and be crying all the time. I don't want you to. I want you to live forever and ever, the way you want to, and I will always love you very much. Please try and forgive me. I will love you always and always, Melissa.

The train engineer, who has a young daughter of his own, saw Melissa cross herself as he applied the brakes. He cannot bring himself to discuss the event.

Melissa Putney is one of approximately 6,000 young Americans who enter the suicide statistics every year. The incidence of suicide in this age group has risen in the past 20 years from an annual rate of 5.1 per 100,000 population to a recent rate of 12.8 per 100,000. The increase in teenage suicide is not matched by comparable increases in the suicide rate of other age groups.

I have a chart here that I would like to present to show you how the suicide rate has changed in the past 20 years in three separate age groups. The top line indicates the 15-to 24-year olds the middle line indicates the 45- to 54-year olds and the bottom line indicates the 74- to 85-year-olds.

Now, what you can see is that the increase in suicides in the American population can be attributed almost entirely to the enormous increase of suicides among the young.

This chart also indicates that it is not likely that this is due to better reporting or better diagnosis of suicides. If that were the case, one would expect to see more modest increases in every age group. So that seeing them only in one age group indicates perhaps that there may be some recent deleterious factor that is preferentially affecting the young. However, if there is a deleterious factor preferentially affecting the young, we do not see that factor operative for each sex and race group.

In this chart we see the increase in suicide for white males, black males, white females, and black females. Males of both races have had an enormous increase in their suicide rate. A modest increase in suicide is seen for white females aged 15 to 24, and there has been almost no change in the suicide rate of adolescent black females.

With this background, I would now like to present the results of an intervention study designed to reduce the occurrence of suicidal, self-destructive behavior among adolescents aged 13 to 17. The intervention program, funded by a grant from the William T. Grant Foundation of New York City, utilized the services of a community outreach worker based at the Boston City Hospital, and a series of conference/workshops specifically targeted for adult human service workers and for student peer leaders in the Boston area.

To determine whether the intervention was efficacious in reducing suicidal behavior, we also studied the outcome of youths at the Brockton Hospital, which is located about 35 to 40 miles south of Boston. No intervention program was offered at the Brockton Hospital. The study sample at both the intervention site—the Boston City Hospital—and at the control site—the Brockton Hospital—consisted of 13- to 17-year-old adolescents who had been admitted to the emergency ward for treatment of injuries resulting from a suicide attempt, a suicide gesture, self-destructive behavior, or for recurrent, uncontrollable throughts of suicide. We identified these adolescents by daily reviewing the emergency room logs and then by reading the physician's report of the admission for every subject who appeared to meet study criteria.

Teenagers at Boston who were suicidal or self-destructive were contacted by the community outreach worker who went to the subjects' homes, talked with them and their families, assessed the needs of the entire family, and then developed a strategy for meeting those needs. This aggressive, direct outreach was based on the belief that adolescent suicidal behavior is the final outcome of multiple deficiencies in the adolescent's life. By reaching out to, following up and providing direct personalized service to at-risk youngsters in the community, the program hoped to affect continuity of medical and mental health care and to improve the quality of the adolescent's life by providing community-based advocacy services to the teenager and his or her family.

Concurrent with direct service, we also conducted a community based educational program which was designed to expand knowledge of adolescent depression and suicide. The educational component was targeted, as I mentioned earlier, to two separate groups: adult human service workers who had daily contact with adolescents—and these included social workers, school nurses, clergy, the police, and court personnel; the second targeted group consisted of peer counselors in Boston's middle and high schools. The curriculum for each of these two groups was different and utilizied separate educational strategies.

The program for adult providers was didactic and comprised both theory and case discussions. The program for adolescent peer counselors was designed to be experiential. We made use of an improvisational theater group composed of amateur adolescent actors who acted out brief skits on adolescent depression and suicide which terminated just at the point of resolution, or rather just prior to resolution.

The adolescent audience was then invited to discuss what might be the appropriate action to take in a given situation. The actors responded to the audience's questions while they were still in character. We found this method to be extremely useful in facilitating a great deal of frank discussion. We were also amazed at the number of participants who reported first-hand experience trying to cope with suicidal friends or classmates—although I might say, having heard the testimony thus far today, perhaps there was no reason for us to be amazed. We were just misinformed.

Although every child enrolled in the intervention program presented a different situation with unique needs, I would like to

share with you a case which can be considered typical by virtue of the multiplicity of problems it presents.

Donna, a 14-year-old black girl, was entered into the program because of a serious suicide attempt involving ingestion of her mother's asthma medication. Donna suffers from a severe orthopedic handicap. She cannot walk without crutches and has to use a wheelchair to get around. Donna has been a student at a school for physically handicapped children, where she had performed well and where she had made a number of friends. Following the completion of the eighth grade, her family had unrealistically expected her to be able to function in a regular school. When this did not occur, Donna felt that she had let her family down and feared that she would never be able to contribute to her family's meager finances by entering the work force.

Work in this case focused on the entire family, with special outreach to Donna's mother, so that she might help revise the family's expectations for Donna's eventual role as a productive adult. At the same time, a great deal of environmental assistance was needed. The community outreach worker helped resolve difficulties with welfare eligibility, with fuel assistance, and with the electric light company that was threatening to terminate service because of an overdue bill.

Recognizing Donna's isolation from her former friends, as well as her limited mobility, the community outreach worker took Donna and her best friend, who is also physically handicapped, on many outings and shopping trips. During these times, Donna was able to talk of her concerns of her eventual ability to work, to get married, to see friends or to become independent of her family.

All of Donna's problems are still very real. Some of them may never be resolved happily. But her family now accepts that Donna needs special assistance to reach her full potential. Donna herself has modified her own expectations. She is eager to finish high school in a special setting and then test the workplace in a sheltered workshop before attempting to enter the general work force.

In assessing the intervention program, we were interested to answer three major questions: one, what is the incidence of suicidal, self-destructive injuries in a population of 13- to 17-year-old youths seeking emergency treatment at inner-city hospitals; 2, is there any evidence that the intervention program was effective in reducing suicidal behavior; and three, are there any characteristics that differentiates suicidal, self-destructive adolescents from other teenagers seeking emergency room care for acute illness?

The third chart that I have here addresses the first question and, in part, the second question as well. I am not sure you can read the numbers, so I will read them for you.

We reviewed a total of 13,125 consecutive emergency room admissions at the Boston City Hospital, which you will remember is the intervention site, and a total of 10,766 admissions at the Brockton Hospital, the control site, for the 2 years immediately preceding the initiation of the intervention program. During this base line period, the incidence of suicidal and self-destructive admissions was essentially the same at both hospitals. There were 16.4 per thousand admissions at Boston, and 16 per thousand admissions at Brockton. However, during the first 18 months of intervention, the

period for which we now have complete data, the occurrence of such suicidal, self-destructive admissions at the Boston City Hospital fell to 13.7 per thousand, while at Brockton is rose to 17.2 per thousand.

These figures indicate a 16.7-percent decrease of study-eligible admissions when Boston is compared to itself, or a decrease of about 24 percent of such admissions when Boston is compared to the control site, Brockton.

In addition, it should be noted that at Boston there was a 70-percent increase of adolescents who sought treatment for suicidal thoughts during the period of intervention. Since these teenagers had not yet inflicted themselves with physical harm, the increase in this category may also reflect the usefulness of the intervention.

Lastly, to ascertain whether suicidal and self-destructive subjects differed from other 13- to 17-year-olds who were treated for other reasons in the emergency rooms, we reviewed the medical records of the study subjects and two comparison subjects matched to the study subject on age, sex and week of admission. We immediately became aware of a high frequency of child abuse/neglect reports, and family violence notations in the medical records of study subjects, but not in the records of the comparison subjects. This observation sparked the hypothesis that prior child abuse and neglect might be a potent risk factor for adolescent suicidal behavior. However, since it was likely that detailed family histories would be elicited more frequently from study subjects than from children treated for things like sports injuries or acute abdominal troubles, we decided that the review of hospital records for this purpose could only produce biased results. Instead, we submitted the names of the study subjects and the comparison subjects to the department of social services, the only agency in the Commonwealth of Massachusetts which is empowered to receive, investigate and deal with reports of child abuse and neglect.

Preliminary analysis of data based 159 suicide attempters and 318 matched comparison subjects reveals that suicidal adolescents are four times as likely as the comparison subjects to have been known to the department of social services during their childhood. A difference of this magnitude is highly statistically significant and implies that such a result is not likely to be due to chance.

We hope to pursue this area of inquiry more fully, but since there are legal restraints on social service records, we are currently investigating possible methods of data collection which would not infringe Massachusetts laws.

In summary, the current study has shown that the occurrence of emergency room visits for suicidal, self-destructive behavior in adolescence is sizable and constitutes about 1.6 percent of all emergency room visits by teenagers aged 13 to 17. The two-pronged intervention combining direct personalized service to at-risk youngsters and an education program shows some evidence of success. The reduction of study eligible admissions at the intervention site and the concurrent increase of adolescents who are seeking help prior to inflicting themselves with physical injury are both encouraging pieces of information.

Lastly, the possible association between child abuse and neglect and subsequent suicidal behavior must be assessed more fully

before any definitive statement can be made. However, if such an association were to exist, specific suicidal preventive strategies might be developed for children known to have been abused and neglected.

[Prepared statement of Dr. Eva Deykin follows:]

PREPARED STATEMENT OF EVA Y. DEYKIN, DR. PH, HARVARD SCHOOL OF PUBLIC HEALTH

Chairwoman Mrs. Boggs, Chairman Mr. Miller, honorable members of Congress, ladies and gentlemen, I would like to preface my testimony on adolescent suicide by sharing with you a brief excerpt from an article published in the Boston Globe on March 23, 1983.

"Sitting on a blanket of oak leaves in the woods behind her school, Melissa Putney and her 12 year old cousin finished their picnic lunch and swallowed the last of the their wine.

Twelve minutes before noon, a tiny white fleck of light appeared far down the railroad tracks the, seconds later, came the crescendo of engines going 100 mph. Amtrak 141—The Bankers—was right on time.

Melissa ran to the tracks, knelt between the rails and clasped her hands in prayer. How cousin Pearl tried to stop her, but Melissa had always been bigger and stronger.

Melissa Celeste Putney made the sign of the cross.

On March 15, Melissa walked the two miles to school. She and her cousin, Samaria (Pearl) Ridgley, slipped out a back door before 11 a.m., walked a half mile across the playing fields to the railroads tracks that carry 52 Amtrak trains past the school every day.

They had brought sandwiches in brown bags and two bottles of wine, according to the Maryland State Police.

The two girls ate, drank and talked, and Melissa wrote the note to her mother, later found among her school books.

I'm very sorry to put you all through the troubles. I think everything I have to do is done. I drank some wine and took some pills, but before I did all that I prayed to my father God in heaven. I asked him to forgive me but he won't. I don't blame him for that."

"Mom, please don't have a nervous breakdown and be crying all the time, I don't want you to. I want you to live forever and ever, the way you want to and I will always love you very much. Please try and forgive me."

"I love you always and always," "Melissa."

"The train engineer, who has a young daughter of his own, saw Melissa cross herself as he applied the brakes. He cannot bring himself to discuss the event."

Melissa Putney is one of approximately 6,000 young Americans who enter the suicide statistics yearly. The incidence of suicide in this age group has risen in the past fifteen years from an annual rate of 5.1 per 100,000 to a recent rate of 12.8 per 100,000. The increase in teenage suicide is not matched by comparable increases in the suicide rate of other age groups. The first chart shows the percent change in the suicide rate over a fifteen year period for three age groups: The young (15–24 years); the middle aged (45–54 years); and the elderly (74–85 years). The denominator in each instance is the rate of suicide experienced in 1960 by each of the three age groups. This chart indicates that the overall increase in the rate of suicide for the total population over the past 15 years is attributable to large increases among the young. These data also refute the possibility that the observed increases in suicide are due to better diagnosis or more complete reporting. If that were the case, we would see moderate increases in the rate of suicide for every age group.

The pattern of a precipitous increase in only one age segment of the population suggests a cohort effect—that is, the possibility of some recent deleterious factor which preferentially affects the young.

However, if there are specific influences which preferentially affect adolescents, it is also obvious that the risk of completed suicide is different according to sex and race. Chart 2 shows the trends in suicide among blacks and whites, males and females for persons aged 15–24.The greatest increase is seen among males of both races, with only modest increases among white females and almost no increase in the suicide rate of black females.

With this as background I would now like to present the results of an intervention study designed to reduce the occurrence of suicidal, self destructive behavior among adolescents aged 13 to 17. The intervention program, funded by a grant from

the William T. Grant Foundation of New York City, utilized the services of a community outreach worker based at the Boston City Hospital, and a series of conference/workshops specifically targeted for two groups: adult human service workers and student peer leaders in the Boston area.

To determine whether the intervention was efficacious in reducing suicidal behavior we also studied the outcome of youths at the Brockton Hospital where the intervention program was not offered. The study sample at both the intervention site and the control site consisted of 13 to 17 year old adolescents who had been admitted to the emergency ward for treatment of injuries resulting from a suicide attempt, suicidal gesture, self destructive behavior, or for recurrent, uncontrollable thoughts of suicide. We identified study eligible subjects by daily reviewing the emergency room logs and then by reading the physician's report of the admission for every subject who appeared to meet study criteria. Subjects at Boston who were study eligible were contacted by the community outreach worker who went to the subjects' homes, talked with them and their families, assessed the needs of the entire family, and then developed a strategy for meeting those needs. This direct outreach component of the intervention was based on the belief that adolescent suicidal behavior is the final outcome of multiple deficiencies in the adolescent's life. By reaching out to, following-up and providing direct personalized service to at-risk youngsters in the community, the program hoped to affect continuity of medical and mental health care and to improve the quality of the adolescent's life by providing community based advocacy services to the teenager and his/her family.

Concurrent with direct service, we also conducted a community based educational program which was designed to expand knowledge of adolescent depression and suicide. The educational component was targeted at two groups of people: Adult human service workers who had daily contact with adolescents that included social workers, school nurses, or clergy, policy and court personnel. The second targeted group consisted of peer counselors in the Boston's middle and high schools. The curriculum for each of these two groups was different and utilized separate educational strategies. The program for adult providers was didactic and comprised both theory and case discussions. The program for the adolescent peer counselors was designed to be experimental. We made use of an improvisational theater group composed of adolescent actors who acted out brief skits on adolescent depression and suicide which terminated just prior to resolution. the audience was then invited to discuss what might be the appropriate action to take. The actors responded to audience's questions while still in character. We found this method to be extremely useful in facilitating a great deal of frank discussion. We were amazed at the number of participants who reported first hand experience trying to cope with suicidal friends or classmates.

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Work in this case focused on the entire family with special outreach to Donna's mother so that she might help revise the family's expectations for Donna's eventual role as a productive young adult. At the same time, a great deal of environmental assistance was needed. The community outreach worker helped resolve difficulties with welfare eligibility, with fuel assistance and with the electric light company that was threatening to terminate service because of an overdue bill.

Recognizing, Donna's isolation from her former friends as well as her limited mobility, the community outreach worker took Donna and her best friend who is also physically handicapped on many outings and shopping trips. During these times, Donna was able to talk of her concerns of her eventual ability to work, get married, see friends or become independent of her family.

All of Donna's problems are still very real; some of them may never be resolved happily, but her family now accepts that Donna needs special assistance to reach her full potential. Donna herself has modified her own expectations. She is eager to finish high school in a special school and then to test the workplace in a sheltered setting before attempting to enter the general workforce.

In assessing the intervention program we were interested to answer three major questions:

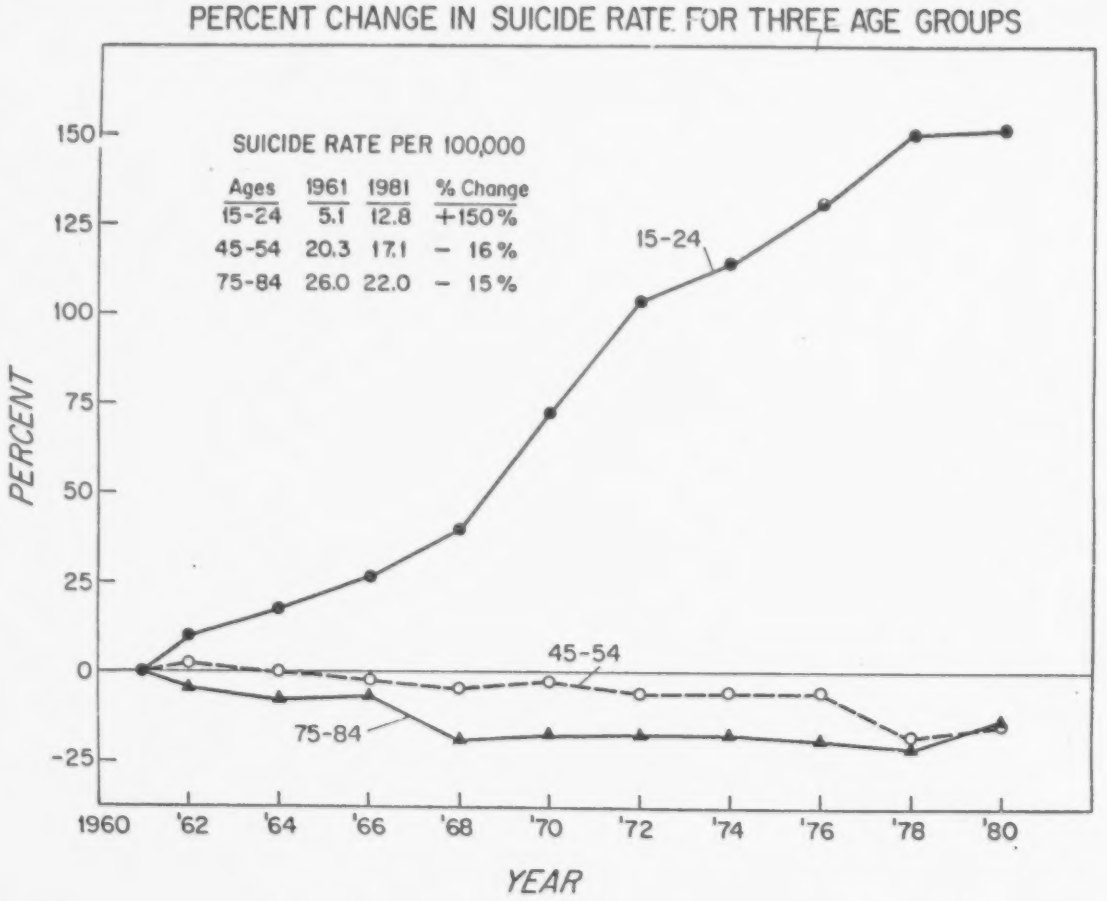
1. What is the incidence of suicidal, self-destructive injuries in a population of 13- to 17-year-old youths seeking emergency treatment?
2. Is there evidence that the intervention program was effective in reducing suicidal behavior?
3. Are there any characteristics that differentiate suicidal, self destructive adolescents from other teenagers seeking emergency room care for acute illness?

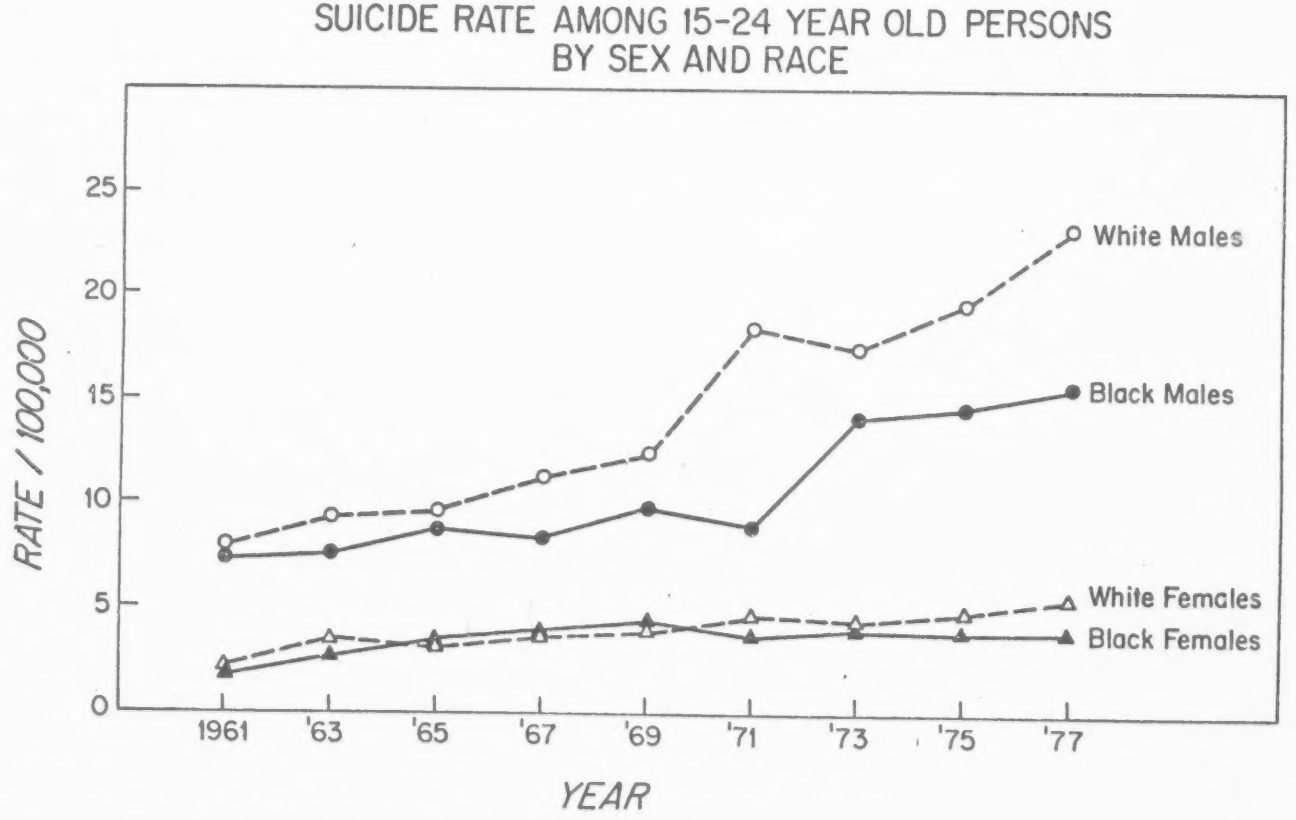
The third chart shows data that addresses the first question and in part the second question as well. We reviewed a total of 13,125 consecutive emergency room admissions at the Boston City Hospital, and 10,766 admissions at the Brockton Hospital, the control site for the two years immediately preceeding the beginning of intervention. During this base line period, the incidence of study eligible admissions was essentially the same at both hospitals (16.4/1000 for Boston and 16.0/1000 for Brockton). However, during the first 18 months of intervention (the period for which we now have data) the occurrence of such admissions at Boston fell to 13.7/1000, while at Brockton it rose to 17.2/1000. These figures indicate a 16.7 percent decrease for study eligible admissions when Boston is compared to itself, or a decrease of about 24 percent of such admissions when Boston is compared to Brockton. In addition, it should be noted that at Boston there was a 70 percent increase of adolescents who sought treatment for suicidal thoughts during the period of intervention. Since these teenagers had not yet inflicted themselves with physical harm, the increase in this category may also reflect the usefulness of intervention.

Lastly, to ascertain whether study subjects differed from other 13 to 17 year olds treated in the emergency wards, we reviewed the medical records of each study subject and two comparison subjects matched for age, sex and date of admission. We immediately became aware of a high frequency of child abuse/neglect reports, and family violence notations in the medical records of study subjects but not in the records of the comparison subjects. This observation sparked the hypothesis that prior child abuse/neglect might be a potent risk factor for subsequent suicidal behavior in adolescence. However, since it was likely that there was a differential history taking at the time of the emergency ward visit with detailed family histories more likely elicited from study subjects than from comparison subjects, we decided that review of hospital records for this purpose would produce biased findings. Instead we submitted the names of suicidal and comparison subjects to the Department of Social Services, the only agency in the Commonwealth of Massachusetts empowered to receive, investigate and deal with reports of child abuse and neglect. Preliminary analysis of data based on 159 suicide attempters and 318 matched comparison subjects reveals that suicidal adolescents are four times as likely as comparison subjects to have been known to the Department of Social Services during their childhood. A difference of this magnitude is statistically significant at $P < .001$. This means that such a result would be due to chance alone less than one in a thousand times.

We hope to pursue this area of inquiry more fully but since there are legal constraints on social service records, we are currently investigating possible methods of data collection which would not infringe Massachusetts laws.

In summary, the current study has shown that the occurrence of emergency room visits for suicidal, self-destructive behavior in adolescence is sizable and constitutes about 1.6 percent of all emergency room visits by teenagers aged 13 to 17. The two pronged intervention combining direct personalized service to at-risk youngsters and an education program shows some evidence of success. The reduction of study eligible admissions at the intervention site and the concurrent increase of adolescents who are seeking help prior to inflicting themselves with physical injury are both encouraging pieces of information. Lastly, the possible association between child abuse/neglect and subsequent suicidal behavior must be assessed more fully before any definitive statement can be made. However, if such an association were to exist, specific suicidal preventive strategies might be developed for children known to have been abused and neglected.


PERCENT CHANGE IN SUICIDE RATE FOR THREE AGE GROUPS
SUICIDE RATE PER 100,000
Ages 1961 1981 % Change
15-24 5.1 12.8 +150%
45-54 20.3 17.1 - 16%
75-84 26.0 22.0 - 15%
15-24
45-54
75-84
150
125
100
75
50
25
0
-25
PERCENT
1960
'62
'64
'66
'68
'70
'72
'74
'76
'78
'80
YEAR


SUICIDE RATE AMONG 15-24 YEAR OLD PERSONS
BY SEX AND RACE
RATE / 100,000
25
20
15
10
5
0
1961
'63
'65
'67
'69
'71
'73
'75
'77
YEAR
White Males
Black Males
White Females
Black Females

Number and Incidence of Study Eligible Admissions Prior to and During Period of Intervention at Both Study Sites

	Prior to Intervention 10/12/79 to 10/12/81		During Intervention 10/13/81 to 4/12/83	
Total E.R. Admissions for 13-17 year olds	Boston 13,125	Brockton 10,766	Boston 9,563	Brockton 6,902
Number of study eligible subjects	215	172	131	119
Incidence of study eligible subjects	16.4/1000	16.0/1000	13.7/1000	17.2/1000
Total suicide attempts	64	36	58	41
Incidence of suicide attempts	4.9/1000	3.3/1000	6.0/1000	5.9/1000
Females	52	25	48	29
Males	12	11	10	12
Total suicide gestures	57	39	28	31
Incidence of suicide gestures	4.3/1000	3.6/1000	3.0/1000	4.5/1000
Females	44	18	17	22
Males	13	21	11	9
Total self destructive	85	96	34	46
Incidence of self destructive	6.5/1000	6.9/1000	3.6/1000	6.7/1000
Females	43	42	19	13
Males	42	54	15	33
Total suicidal ideation	9	1	11	1
Incidence of suicidal ideation	0.7/1000	0.1/1000	1.2/1000	0.1/1000
Females	2	1	9	1
Males	7	0	2	0

Mrs. BOGGS. Thank you very much.

Dr. Giffin, if you will excuse me just a minute to make an announcement, we have just been told that this room is engaged for 2 o'clock, so I'm a little afraid of taking a luncheon break. But if anyone wants to run down to the cafeteria or something to grab a bite, that's fine. But we will just proceed with the testimony because of time constraints.

Dr. Giffin, I must tell you that you had wonderful coverage in the New Orleans Times Picayune States Item. I was so pleased to discover, when I came back from home one weekend and suggested that we ask you to come to testify, that you were already coming. So it is very nice to have you.

STATEMENT OF MARY GIFFIN, MEDICAL DIRECTOR

Dr. GIFFIN. Distinguished Congresspeople, ladies and gentlemen, panel, I am delighted to be here. If I were Mrs. DiFiglia, I would be thinking that statistics are a little bit like a bikini: What they reveal is fascinating, but what they conceal is crucial.

You have in your hands my written testimony, a summary of that testimony and the book. In view of the excellent presentations by the second and third speakers and by our distinguished parent to my left, I would like to acquaint you with some children that I have known and whom we have tried to help.

I would like first of all to tell you about Stan. He was 17. The school social worker, a man, called, saying Stan has all the signs that you have told us indicate serious suicidal risk. I inquired as to what had been done at the school. In fact, the social worker had tried very hard to contact him. A seemingly beloved teacher had talked with him. He was reported as having written a suicidal note to his girlfriend and he had given away his favorite stereo.

The latter has come to be one of our chief indicators, what we call the writing of the will. It, in fact, is not a legal document, but in practice, in action, the suicidal adolescent creates his will by giving away his beloved possessions.

Given that data, we responded by making an appointment 45 minutes hence. In the clinic, Stan was a lovable looking boy; he was the kind of person that you want to take home with you. He did not think he should be in a shrink's office, but he was willing to talk. I told him that I didn't ask to see him, and he hadn't asked to see me, so we were in the same boat, and how could we spend 50 minutes?

At the end of 50 minutes, it was quite clear that this boy did not want to kill himself, that he was desperate, that he did not know what was so important to his mother that he could not share it with her because she might be disappointed, and he was aware that he had come from a family that had given him everything.

I suggested that mother and he and I sit down. She left her job later that afternoon to come and we had an equally useful three-way conversation. It seemed quite clear that if some adult could help this boy realize that his mother would rather know anything and everything than nothing, he could be kept from suicide.

He was told that he had to see somebody. It didn't matter whether it was myself, somebody at the school, the social worker, a teach-

er. It didn't matter, but he had to see some adult who could help him with his problems.

He elected Big Mac, the drama teacher at the high school. I had known Big Mac for many years because he has been a friend to many troubled teens, as many drama coaches are. We called Big Mac and Big Mac was very willing to find some tasks for this boy, recognized his previous dramatic talents and was quite eager to take on the responsibility.

His contacts with Big Mac have continued throughout this year. I checked up on Stan not long ago and he is doing very, very well. He sees his panic and his driveness of some 9 months ago as a phase and he is grateful that somebody came along to help him out.

That is the kind of work that is possible when you have a very close link with a local high school and when you have excellent teachers and social workers in the schools.

Let me tell you in contrast about Rachael, who, if you have a book in front of you, is depicted on page 253. Rachael is a child who has been threatening suicide for many, many years and she is what we call an oppositional child. She sticks her heels into the ground and will not cooperate, and the more you try to be helpful or supportive or empathetic, the more she says in her action, "I will have none of that for me."

Yet, she continues to write letters and poems depicting the fact that outside she can put on a good front, but inside, she is hiding her feelings. The poem on page 253 in the book depicts that with the final two sentences, two lines, "and thanks to that, I've tried to take away my life by cutting my wrists with a knife."

She will not cooperate; she will not see anyone at school; she will not see me. The question then was, how do we try to protect this child? What has happened is that she and I have become poetry friends. She shares a poem with me and I write bad doggerel back to her and she responds in much better poetry perhaps 2 weeks later.

This has gone on for three years. She is still alive. She has made no further suicidal attempts since we began not working together, and we seem to be almost at the end of this particular period in her life.

Similarly, I would like to tell you about Susan, who is also in the book on page 153. Susan came to us referred by a pediatrician because of anorexia nervosa at the age of 10, a tiny little girl, lovely in looks, who had lost half of her body weight in the preceding year. She was basically depressed. It turned out, after a long period of therapy in which she and I shared drawings, colorings, rainbows, poetry, the thing she was afraid was that she thought her parents were going to divorce. They, in fact, were not. As a matter of fact, they were two of the most loving parents I have ever known, but they were so gentle that they never shared any of the negative affects.

When she heard them fight one day, she thought that meant that they were going to divorce. And in her 10-year-old mind, she had put together the idea that divorce was going to come and that she somehow was the reason for that. Once that became clear and we could clarify the situation, call in the whole family, talk about

it, comment upon what, in fact, her family had tried to offer, she began to eat and she gained back half of her body weight in the next 2 months.

Let me add just a fourth case, a case of a family in which the father killed himself, a good family, a professional family. The father was a teacher in one of our universities; the mother was also a teacher. There were three teenage children, two boys and a girl.

The father suicided one November evening and for 6 months, all four family members were suicidal. They felt that in some way they must have driven father, husband to this suicide. They could not shake themselves of that guilt.

Here, also, is an example where the clinic must move in. We cannot use the school for this kind of a predictment, but after practically daily contacts, including weekends, many telephone calls from all four members of the family, that family is now on its way. Two children in college and the girl a graduating senior.

So it is possible, if we can get a hold of suicidal people, it is possible to help them. The task I think that all of us feel is the task of somehow or other knowing which particular adolescent is in serious trouble and as we have heard so eloquently in this panel, it is not always possible for the adult, willing parent, to know that.

Thank you.

[Prepared statement of Dr. Mary Giffin follows:]

PREPARED STATEMENT OF MARY GIFFIN, M.D., MEDICAL DIRECTOR

You have heard a great deal of testimony supporting the importance of the intact family. Children were meant to be reared by two loving adults who are child focused during the child's early years, and family focused throughout the rest of the child's formative years. Biology is inevitably the basis upon which healthy psychology and sociology develop. When we reverse that process, as we are doing in the 1980's, we are in trouble. I could testify that infants and, therefore, children and adolescents, are an endangered species, subjected to the destructive forces of current values and narcissistic goals. However, you asked me here to testify on the subject of suicide.

During the past seven years I have been catapulted into the midst of the so-called "suicide epidemic." The community clinic of which I am the Medical Director lies in the heart of an affluent suburban Chicago area in which the rate of successful adolescent and child suicide has tripled in the past ten years. Our service area has the highest successful suicide rate in Illinois. Violence manifested in accidents and homicide has similarly increased.

Not only are the statistics staggering, but also, intermittently, there have been epidemics of suicides similar to that reported from Plano, Texas. The domino effect of one suicide upon a classmate or friend—the seemingly epidemic effect—galvanized us into action against suicide. It quickly became apparent that some of our adolescents and children were balanced upon such narrow fulcra that they were especially vulnerable to what would seem to be the usual stresses of adolescence. When the option of suicide was acted out by a classmate they too chose that option.

As we explored the lives of the children who killed themselves we were struck by the frequent interruptions between the caretaker-parent and the infant in the first ten months. Recurrently, both from our post-suicidal reconstructions, and from the popular and professional literature we read and heard the details of interruptions and unpredictabilities between the infant and his nurturing adult, with and from whom he must develop a basic sense of trust and acceptance. Basic to their relationship is the communication, first entirely physical, later inter-personal. Communication is first based on food and touch, on visual and auditory stimulation and response, on breathing together and caressing; finally, it moves into gesture and response, babbling and words, assertions and limitations; then finally it emerges into the uniquely human phenomenon of language and verbal communication.

Recurrently in our post-mortem reconstructions and from the literature, we noted the breakdown in communication which occurred in families just prior to the suicide. Repeatedly, parents exclaimed, "Why didn't he tell me it was so difficult?" or "What could have been all that bad that she had to kill herself?" Anyone who has

reared adolescents knows the frustrations which are universal in trying to communicate with children in their teens. However, usually they talk with their friends; our suicided children did not do that either. The children who succeeded in killing themselves seemed to have more inhibition and more static in their communication than most adolescents. They were twice blocked: first in sharing with their families and secondly in opening up to their friends.

In addition, we were caught up in defining the differences between those suicidal children who actually kill themselves and those who threaten but do not act, or act with such mixed feelings that they are inevitably saved. What was it that made it acceptable to attack one's own body, to destroy it with drugs, trains, hanging and gunshot wounds? What made it acceptable for these children not to protect their bodies? Again, we were taken to the study of infancy. Forty years ago Rene Spitz and others pointed out the self-destructive, self-attacking behavior of children between 7 months and 2 years, who had lost a beloved primary love object.

We often speak of the X factor in mental health; some of us define it as the capacity to play. The person who can be playful whatever his age; the adult who can communicate with feelings and thought mixed with fantasy, as well as good reality perception; the child who can amuse himself even as he can also relate to his peers; the child of any age who develops the playfulness of humor, especially when that humor includes poking fun at himself; these children usually develop the hope, the humor and the humility which lead to good mental health.

Perhaps the Y factor in many emotional and psychological problems, and especially in suicide, is the lack of such humor and playfulness. It is in the process of rolling with the punches that a personality with a broad fulcrum is developed. If one's personality is balanced on a broad fulcrum, if the person can roll and adapt, he cannot only adapt but have the hope for that adaptation, even as he faces adversity and disappointment. Central to the capacity to play is the ability to communicate, and to expect responses. Such communication is built upon the early mother-infant communication. As it becomes internalized, play with others becomes possible. As language is developed, verbal communication accompanies the play and true socialization is possible.

Inherent in the successful mother-infant interchange in the early months is the song without words which is the communication of the early months, communication which develops its only play quality. Inherent in this interchange is the acceptance and love of the child's body, and then the child's awareness that his body is worth being cared for. We do not yet know if this is the Y factor but our thoughts catapulted us into action.

If the parents were out of communication with the potentially suicidal adolescent, who might be the person-option to catalyze emotional and verbal interchange not possible at home? The classroom teacher was elected without running. She or he could offer a different style, a different set, perhaps a more neutral interchange with the troubled adolescent. If the potential suiciding child was balanced on a narrow fulcrum what might broaden the base? The answer was playful interchange with peers. Our action against suicide had taken form.

With these ideas in mind, we developed a series of seminars for social workers and other pupil personnel service staff to sell them on the idea of accepting still more responsibility than they already carried. Now, three years later, and with the advantage of excellent professional workers in the schools, we have a network of teachers reporting worrisome children to social workers in the school; consultations with the clinic are available but often not necessary. Once it became the accepted assumption that the teacher was the person with the relationship, even if tentative and that she had an advantage over all of the so-called experts in mental health, the teachers were willing enter the breach.

Buttressed by the school social workers, and aware of our support and encouragement, to say nothing of our gratitude, the teacher is urged to confront the troubled child with what she observes: depressed sounding poetry, a hopeless theme in a short story, declining application in studies, a sense of isolation. As the child, begins to feel support to his narrow fulcrum and a holding environment eager to help, communication is restored in most cases. Years ago we had as policy that school personnel should withdraw when a child was suicidal; the condition was considered too ill to be seen at school. By following that policy we lost the greatest ally for the child, namely the person who had seen him every day and often for hours at a time.

Similarly as mental health issues are added to classroom discussion in health, the suicidal student enters into at least a passive interchange with peers and, hopefully, the comfort which will permit a more active involvement with his peers. As he hears his classmates discuss death, suicide, drugs, separations, sex, loneliness and fears of not being liked, the suicidal adolescent begins to play with his demons and

his distortions, eventually sharing some of these with friends with whom he did not previously communicate. With the knowledge that adolescent pressures are universal, the potentially suicidal child becomes freer to choose constructive rather than self-destructive options.

Another aspect of our work has been that of post-vention, namely the use of death as a catalyst for those left behind to become aware of their own fears and distortions about death in general. Especially in children the face of death is difficult to integrate and is often denied. Realistic discussions abut the finality of death; the sharing of feelings about losses already experienced, widens the sense of the emotional impact of death in any form, and especially by suicide.

Suicide is, after all, our most preventable disease of children. We have the responsibility to inject our medication, open communication into people touched by vulnerability. Might it have been possible that some of the suicides in Plano and in our area could have been avoided if we had been more aggressive in our insistence on medicating? I think so.

Finally, I would like to say that the longer we are involved the more optimistic we have become.

Mrs. BOGGS. Thank you so much, Dr. Giffin.

Mr. Fish, I will defer to you for your questions.

Mr. FISH. Thank you. It has been very valuable to hear from this panel and I look forward to reading your material in greater depth. I have no particular questions at this time.

Mrs. BOGGS. Ms. Johnson.

Mrs. JOHNSON. Yes, thank you.

I would like to ask Dr. Deykin if, in your work, you have had any indication of the relationship between broken homes and suicidal tendencies, since that was something that was so brought out by Ms. Smith.

Dr. DEYKIN. It is very difficult for us to assess that in our study because we are dealing with two populations in inner city hospitals where the occurrence of single-parent homes is almost 100 percent. We have no way of assessing whether there is an association with broken homes and suicide because almost the entire population—of children who come into the hospital with suicidal injuries also come from broken homes and thus we are not able to assess that in our study.

Mrs. JOHNSON. That particular characteristic of your population, is there any correlation between that and abusiveness?

Dr. DEYKIN. There is a high occurrence of abusiveness in the population as a whole. About 8 percent of the children, in the area have had 51-A reports which are child abuse and neglect reports. In our suicide sample, about 16 percent had experienced child abuse or neglect and 4 percent of the control group. Overall, 10 percent of the entire population of children in the area had experienced child abuse/neglect.

Mrs. JOHNSON. Yes.

Dr. GIFFIN. May I speak to that, because my population is from a different area, and I think it is important for the panel to recognize that Plano, Tex. and metropolitan Chicago offer different kinds of family patterns. We do not have high child abuse and we do not have high divorce among our suicide adolescents.

Mrs. JOHNSON. That is very interesting.

Ms. SMITH. I would like to reply to your question about the relationship. The recent study that Dr. Kim Smith did shows that there is a very high significant relationship, high correlation between divorce rate and adolescent suicide, and between single-parent families and adolescent suicide.

Mrs. JOHNSON. What happens to these populations? People who go through serious suicidal periods in their adolescence—are they more likely or less likely or do we know anything about the likelihood of their being suicidal as adults? I don't know if there is that relationship.

Dr. DEYKIN. Yes, a previous suicide attempt is a very potent risk factor for a completed suicide later on. Youngsters who have made a suicide attempt in their teenage years are at higher risk than adolescents who have not made a suicide attempt, of completing suicide sometime——

Mrs. JOHNSON. In their adult years.

Dr. DEYKIN. Or sometime later on. One suicide attempt is already a potent risk factor; two is not twice as much, it is five times as much and so on. It is an exponential curve.

Dr. GIFFIN. Again, may I throw in the clinician's point of view rather than the statistician's? If the person is treated successfully, those risks decline.

Mrs. JOHNSON. That was going to be my next question. That is very interesting. Does anyone else have any comment on that point?

Ms. SMITH. The figures say that for every suicide attempt, one in 10 will die within 10 years of suicide and 40 percent eventually will die from suicide.

Mrs. JOHNSON. And we don't know actually whether those statistics would be ameliorated by whether or not they received treatment.

Ms. SMITH. Well, I think Dr. Giffin spoke to that. Yes, suicide is a way of communication and it depends very much on what happens as a result of that attempt for communication, whether they will attempt again.

Mrs. JOHNSON. Thank you.

Mrs. BOGGS. Thank you very much.

Ms. DiFiglia, I am sure that since Scott's death that you have looked into various modes of communication and various help groups and so on that exist, not only specifically in your area, but in other areas as well.

Can you give us any kind of advice on how we can help parents and children in other communities recognize how important it is to communicate and do you feel the Government can provide any kind of assistance to these programs?

Ms. DIFIGLIA. I would like to say here that I think a lot of parents—we have, as a result of this, we have gone to several suicide prevention programs that our church has provided and the community has provided. Of course, you say that is a little late for that, but there is—anything that we can do for any of the other children in the community, we certainly are going to, but let me say here that there was a lot of work that went into these suicide prevention programs.

We were speaking about that before. How many programs can you provide and people go to? Now, in a community like ours, where all of this has happened, you would think these rooms would be filled, especially at this church where there is such a large congregation. For the first few, it was not. And those programs were excellent, excellent.

The second program that we had there was filled with children, only because the children were brought there from a regular classroom where they were having religion instruction and I can tell you that meeting was absolutely fantastic. The kids responded. They had questions. They did not have enough time to get through all the questions that the kids had.

Like we said before, there are so many—you can do so many programs for the children and the parents, but if they are not responding—and I think the reason parents in this community probably were not- -it is not that they weren't concerned; it is the fact that they didn't think it could happen to their family.

I felt the same way before it happened. When I read about the children who committed suicide before, I did not know them other than my children knowing them from going through the same school, and I naturally associated it, like I said in my testimony, to kids being strung out on drugs or alcoholic problems or family problems, whatever. And until it happened to us, I did not realize that it could happen in a family where there were not specific dangerous problems.

That is one of the reasons I like to speak about it because of the fact that it can happen to normal families where there isn't all the divorce. There is no divorce in our family. As a matter of fact, before this happened, I think my husband and I have had a—we have been able to get through the grief process a little bit easier than most people; we do not have the guilt feelings that most parents have as a result of this.

I can't even remember the last time we had an argument in our house before this happened, not that we don't have arguments, we have the normal problems of teenagers. But what I am trying to get across is that it can happen in normal families where you feel there is not a problem. With the community doing as much as it can, it is the schools that have just come out of the woodwork and they are offering many programs, but if you are not getting children there and parents interested, it isn't going to do any good.

Mrs. BOGGS. You said two things that struck me very specifically and one is that so often the most loving, wonderful children don't wish to hurt their parents, particularly their mother, with any kind of unpleasant news or feelings and so on; and the other was that if they only realized how final it is. I am not sure that all teenagers realize that suicide is as final as it is.

Do you think there is anything that this committee can recommend that would be helpful to programs so they could expand the opportunities for young people and their families, and young people and other adults, to be able to communicate and prevent suicide?

Ms. DIFIGLIA. I think what I would like to see as a result of this is some publicity as a result of this committee. Having the little girl here and the doctors that we have here, it is just incredible. It is like Kim said, and her mother said, you have all of this going on here and it is so effective here, but what happens to it when we go back? What happens with the TV cameras? They only show a few minutes of it.

I would love to take this whole panel back home with me to the Plano area and show them how this could affect the lives of others. Like I said in my testimony, too, I think talking about it, making

people aware of the rising statistics. We need to have a little bit more positive publicity on it. We have had some very bad publicity in our area.

As far as this committee is concerned, I think if we can get some publicity as to what this committee is trying to accomplish, that would help a lot.

Mrs. BOGGS. Thank you very much and I must tell you that Scott lives in all of the young lives that you are saving.

Ms. Smith, it seems unbelievable that so many suicides could occur in one community. Do you feel there is an identification factor operating where a troubled teenager will identify with a teenager who has already committed suicide?

Ms. SMITH. Yes, and the closer that identification, the higher the risk for suicide. It is not that one suicide causes another young person to take his or her life, but with identification comes modeling and they will copy.

The closer the relationship in a family, the higher risk there is for suicide. If the father commits suicide, the son is at higher risk. So that same type thing would happen in a high school, also, yes.

Mrs. BOGGS. Do you think, then, that it is necessary or important to target services to those young people who have known a teenager who has committed suicide?

Ms. SMITH. Yes, and our center has done that. In fact, the night before I came here to Washington—time goes here, I think that was Tuesday. I was contacted by a person at Southern Methodist University and one of the sorority girls had killed herself the night before. They were asking our center if we would come and meet with those girls, which we will do. I am here and will not be able to meet with them today, but as soon as possible.

We did that in Plano also. We will go into a high school immediately after the suicide and meet with the close friends.

Mrs. BOGGS. I was very interested in the kinds of services that you have set up and also that you hope to continue to set up and to expand into. I am sorry Kim is not here to hear that you have peer counseling groups going on.

Ms. SMITH. Wish she lived in Dallas; we would love to have her.

Mrs. BOGGS. Well, you know Kim and Mr. Dyack did tell us that their council and council members are willing to go around to different places and I think we should take advantage of that.

But how do you man your 24-hour hotline?

Ms. SMITH. We have volunteer paraprofessionals that go through extensive training, over 50 hours of training, to—we teach them communication skills. We teach them how to listen, how to respect, how to convey understanding and caring and a lot of academic work in understanding what it is to be in a crisis.

These individuals volunteer their time. They will take one shift a week, 4 hours a week, and we have about 100 volunteers to be able to do this.

Mrs. BOGGS. How are they trained? Who trains them?

Ms. SMITH. I am a trainer. We have a professional staff, a clinical staff of four, and we also train the volunteers themselves to be cotrainers, to be able to do this.

Mrs. BOGGS. I notice that you talked about the fact that a suicide prevention curriculum will be developed and that it will be man-

dated in the Dallas Public Schools. Is your group helping to develop this curriculum?

Ms. SMITH. Actually it went the other way around. I developed the curriculum and offered it to the schools, and before it could be used in the classroom, here came a mandate from the superintendent to do this, which was nice. They just said, "Hey, we have already done it."

Mrs. BOGGS. When you speak of training elementary and secondary school counselors, in crisis intervention, it seems to me that you are meeting some of the criteria that have been mentioned previously—that we really should reach down to children who are younger than just the teenage children.

Ms. SMITH. That is right. I was delighted that the elementary school counselors were included in this workshop, yes.

Mrs. BOGGS. Do you think that there is any way that this committee can be helpful in suggesting legislation or Government programs that could be helpful to your activities?

Ms. SMITH. I would encourage you to support research, No. 1, and I think Dr. Susan Blumenthal has already spoken to this. I think one of the National Institute of Mental Health goals is to reduce adolescent suicide rate by 1990 and they are putting funds into that effort.

I guess, second, I would encourage you, perhaps, to support crisis centers such as ours. Our center is very fortunate in that we have been able to exist without Government funding and no United Way money, either. This is from a community such as Dallas, who has really been tremendously supportive, but there are many communities around the country that don't have the same needs.

There are 33 centers that are accredited by the American Association of Suicidology and funds are very difficult to come by.

Mrs. BOGGS. Thank you so very much.

Dr. Deykin, what do you feel we need to know in the field of teenage suicide? What type of research?

Dr. DEYKIN. I think we do not know enough about the risk factors. We can usually identify a potentially suicidal adolescent after they have done something. That often is more than halfway down the line. It would be very nice if there were some way that we could identify specific risk factors that might be able to target someone before they have to make a serious attempt or a gesture.

That is why I was particularly encouraged by the fact that at the intervention site, there was an increase of children coming to the emergency room with the specific complaint of having suicidal thoughts. In a sense, they were psychiatric emergencies, but they had not done anything to themselves. I felt this was a particularly useful thing.

If there was some way of identifying people at high risk before they do something, that would certainly be a way of reducing the total suicide rate in adolescents.

Mrs. BOGGS. I was so impressed with the fact that you had one social worker who could be in an outreach program that produced such remarkable results.

Dr. DEYKIN. We had one community outreach worker who was a trained social worker. In addition we also served as a placement for the BU School of Social Work and provided experience for two stu-

dent social workers. Because of this, we had more manpower than just a single social worker.

We were able to offer direct service to 118 children, of whom 40 received service beyond 10 hours. The majority of children received less than 10 hours of outreach service.

Mrs. BOGGS. We have all worked in community services where we know that social workers do a lot of moonlighting on their time in other programs. They are remarkable, but how costly was the crisis intervention that your study provided, both the direct crisis counseling and the community education program?

Dr. DEYKIN. The direct service comprised the community outreach worker's salary, which was $18,000 a year and about $2,000 a year for patient costs. This included outings for subjects, subscriptions to the local museums which were quite popular for kids, special treats and so on. In addition there was a 15-percent institutional overhead charge, so that the direct service component came to something around $25,000 for the year.

The educational component on a yearly basis came to $2,400. We made use of the fact that Boston is filled with many people who are involved in social psychiatry. They provided their time free of charge in most cases.

Mrs. BOGGS. In your opinion, could most hospitals afford to institute similar services?

Dr. DEYKIN. It would seem to me that it is not a question of whether they can afford it, but can they afford not to? Preventing even one emergency room admission, would reduce hospital expenditures by $200 to $400, which is what an emergency room visit now costs at the Boston City Hospital.

Well, if you could prevent that, especially when you consider that many of these children have to stay in the hospital overnight if they have had a severe injury; they have to have overnight care, at least overnight, with special nursing and so on. If you could reduce emergency room utilization even slightly, you will have made up your costs.

Mrs. BOGGS. Do you see any role for Government in providing crisis intervention services for suicidal teenagers?

Dr. DEYKIN. I share the other panelists' view that a very useful function would be to indicate Federal concern for this problem. I don't know that it is within the bailiwick of the Federal Government to legislate specific guidelines. I think that the States themselves have ultimate responsibility for this.

Certainly the allocation of funds to this area, and to the health area in general has suffered greatly, as you know, in the past few years at the expense of defense. This is one thing that I would hope the Federal Government would take a look at.

Mrs. BOGGS. Dr. Deykin, Mr. Miller could not come back because he has another hearing, but he has asked me to propose this question for him.

To your knowledge, have there been other studies in the field of suicide research that utilize a comparison, a control group model, as you have done, and how many teenagers actually received crisis services in your study—you have referred to that. Can you explain in simple terms why the study design you have employed enhances

the value of your results, even when those results concern only 115 or more teenagers?

Dr. DEYKIN. To my knowledge, there has not been another intervention trial. There has not been an intervention trial with controls in the area of suicide. Intervention controlled trials, of course, are commonplace in many other forms of illness: Heart disease, cancer and so on, but to my knowledge, there has not been a control trial in the area of suicide.

There have been studies that have compared suicidal attempters with other people, but the question was not so much, "Can we prevent a future attempt or reduce the occurrence of this behavior?" It was to look at background characteristics.

Other studies have examined the characteristics of suicide attempters and comparison subjects so there have been studies of risk factors. To my knowledge, however, there has not been a controlled intervention study.

Perhaps someone may know of one, but I have reviewed the literature and have not been able to find one to date. The total number of children youth served was 118, as I indicated to you, and then I am sorry—the last question that Mr. Miller asked about?

Mrs. BOGGS. Can you explain in simple terms why the study design you have employed enhances the value of your results, even when those results concern only 115 or so teens?

Dr. DEYKIN. In a controlled study, one is able to determine to what extent a treatment or an intervention was efficacious because of the enrollment of a separate group that did not receive the intervention. Such a group represents the natural course of events.

If you only have a single group to whom you are providing the intervention, it may be enormously effective, but you can never show the effectiveness. You can never show what would have happened if the intervention had not been given.

Mrs. BOGGS. Thank you very, very much.

Dr. Giffin, I really thank the Lord for your many talents. I was very interested when you talked about the exchange of poetry, in relation to Kim's insistence that peers could also reach out to each other and help in this way.

We should probably get a list of talented poets to make certain that we have people on board to respond to other teens. We can't expect you to answer all of them. [Laughter.]

Mrs. BOGGS. We are very grateful for the work that you do. I have a granddaughter who is talented at poetry and I have learned a great deal more about her than I would have known otherwise.

Can you describe in more detail for us the content of the suicide section of the health curriculum that your center developed?

Dr. GIFFIN. We have included suicide as one of the topics that needs to be discussed along with the others usually recognized, such as sex, separation, friendships, separation from family as well as from peer groups, and we have found that when it is woven into the group discussions, the suicide discussions become extremely frank and very emotionally laden and actually take more time than any of the others.

So that clearly this topic of suicide is on the minds of many, many early adolescents and late. As a matter of fact, that curriculum has now been introduced into fifth grade. We went through

junior high and high school; we are now moving down as the age of successful suicide decreases toward the 9-year-old.

We have simply woven it in as one of the topics and have tried to speak very frankly about it, putting it in with sudden death of all kinds and the problems that any death at any age create.

Mrs. BOGGS. Do you have some feedback from the students exposed to the curriculum that you can share that indicates how it is received?

Dr. GIFFIN. Probably one of the most exciting phone calls I have had in the last 6 weeks was from someone who had just finished a sequence and she called saying, "I talked to three of my boy friends,"—not boyfriends, but boy friends—"and I think they all need to come in and you better start a group for them." [Laughter.]

So we are now getting referrals from those students.

Mrs. BOGGS. That is very exciting. We are most grateful to all of you to take your time and to bring your considerable talents and expertise to us.

Mrs. JOHNSON. Madam Chairman.

Mrs. BOGGS. Excuse me, Nancy.

Mrs. JOHNSON. Before you dismiss the panel, may I ask one more question?

Mrs. BOGGS. Certainly.

Mrs. JOHNSON. Dr. Giffin, as we have all sat here and talked, I have been looking at your testimony which, in its written form is quite different from what you gave, and I wondered if I might ask a couple of questions about your written testimony

Dr. GIFFIN. Surely.

Mrs. JOHNSON. Could you enlarge a little bit on what you believe to be the relationship between interruptions between caretaker parents and infants in the first 10 months of life and disposition toward suicide?

Dr. GIFFIN. You will notice in that first paragraph, I referred to the endangered species, which I believe infants are. If I may digress for 2 minutes, to use an Audubon Society analogy, for many years the gull population in Door County was falling off and it was recognized that the shell that was seemingly normal was cracking too early and so the chick did not have to push his way out, but the shell cracked and he was born prematurely.

I think that analogy is true for our present infants. I think that there is not a long enough holding environment between mother and infant and there is not a close enough bonding experience. If I were asked the question that you were asking earlier, what can the Federal Government do, I would wish the Federal Government could support research to check on the validity of this thesis.

I think it is vital. I think if it is true, then the Federal Government will have to face the fact that they are going to have to train and license parents.

Mrs. JOHNSON. A second question, also—well, just back to that previous question. Would you—you are then saying that really one of the things we need to look at in terms of research is the relationship between infant parenting and——

Dr. GIFFIN. Most of the studies seem to be corroborating the impression that most of us have that communication is a major problem. It may be a subtle problem in communication or it may be a

flagrant one. If the basis for communication is the early bonding experience where mother and infant communicate with one another long before there are words, then we have to go back and study the subtleties of that interaction.

Mrs. JOHNSON. Then finally, would you talk a little bit about how we can treat and prevent suicide and perhaps what might be the Federal role—you describe in your written testimony your use of the existing school setting to identify and treat——

Dr. GIFFIN. Yes; the case that I gave as case 1, Stan, was an example of that, where the school social worker had learned through our seminars what we consider the indicators of serious suicidal threat, and that social worker called, reporting, "We have such a case, please help us out."

That is a result of a series of seminars given for teachers, not social workers, for teachers to detect what seemed to be the early indicators of a suicide.

Mrs. JOHNSON. As teachers detect those early indicators, are they part of the treatment chain——

Dr. GIFFIN. Yes.

Mrs. JOHNSON. It implies here that they can——

Dr. GIFFIN. That is correct, they remain the therapist. We act as consultants.

Mrs. JOHNSON. So you work in a sense through them——

Dr. GIFFIN. That is right.

Mrs. JOHNSON [continuing]. By educating them to early signs by educating them to handle the situation, primarily because of the importance of communication——

Dr. GIFFIN. And because they have been available so they are a known entity.

Mrs. JOHNSON. I think it is a point worth noting because as I am very much involved in the whole Nation-At-Risk and the Century Fund and all of those other education studies—and having just graduated my youngest of three from public high school, we see the money that we are putting into counselors in public high schools is basically going to scheduling and academic counseling.

As we move toward a career curriculum, which I expect that we will, we ought to be freeing up some resources and if we use those people perhaps to educate them, and use them as vehicles for the kind of curriculum that you have found effective, we may be able, even within our existing resources, to do a very much better job.

Dr. GIFFIN. Yes.

Mrs. JOHNSON. I am very interested to see that you have found schools to be an established mechanism that could be better utilized to identify and address this problem.

Dr. GIFFIN. Teachers lend themselves very quickly to this role if they have proper support and supervision.

Mrs. JOHNSON. Thank you very much.

Mrs. BOGGS. Also, Dr. Giffin——

Ms. DIFIGLIA. May I add to that?

Mrs. BOGGS. Of course, Mrs. DiFiglia.

Ms. DIFIGLIA. Mrs. Johnson, I would like to add to that. That was one of the things I wanted to bring up. Our schools in Plano are very big. My son graduated with 1,500 students in his class and the counselors there—they are fabulous counselors but they have too

many things to do with scheduling that they do not have time to counsel. It is not their fault.

Mrs. JOHNSON. That is right, but we might be moving into a period for other reasons that might allow us to redeploy them.

Ms. DIFIGLIA. I hope so.

Mrs. BOGGS. Dr. Giffin, do you think that we should develop some programs that enhance training in parenting in schools?

Dr. GIFFIN. Yes; I do. I feel very strongly that that is an omission in most curricula. There have been some fine programs using nursery school and younger infants of actually a part of the public school. They should be activated again.

Mrs. BOGGS. We had some very good testimony in our southern regional hearings from a remarkable woman who had been associated with the school system and decided to work with the problem of teenage pregnancy. What she discovered was an integrated way of making everybody conscious of what it meant to be a parent and what life was really all about, that was more effective prevention than trying to attack just the sexuality content.

One of the amusing things that she said was, "You can certainly disabuse a teenager of wanting to have a baby so she will have something that is all her own if you just expose her to enough 2-year-olds."

Dr. GIFFIN. Right. [Laughter.]

Mrs. BOGGS. We do thank all of you so very much and it is remarkable that you are willing to share with us all that you have to offer.

Thank you so much.

Mrs. JOHNSON. Thank you very much.

Mrs. BOGGS. Thank you, Nancy.

We have a vote on but Mr. Fish has gone over to answer it and will come back and I will go when he comes back so we will go right on with our next panel, please.

We are very happy to have all of you with us and I will introduce all of you and then we will proceed and then ask questions at the end.

Deborah Shore, we welcome you, the director of the Sasha Bruce Work, Inc., from Washington, D.C.; Joseph Covino, the library director at the Great Neck Library, Great Neck, N.Y., who is accompanied by Danny Sonenberg and friends. We are so happy all of you who have come down to participate and are very proud of your sponsoring organization for realizing that it was something important.

Joseph Stewart, the director of Center 54 and Rheedlen Foundation in New York City, accompanied by Victor Marte.

Dr. Joseph Novello, who is the director, Child and Adolescent Services of the Psychiatric Institute here in Washington, D.C.

Thank all of you for being with us and, Ms. Shore, we would like to hear from you, please.

STATEMENT OF DEBORAH SHORE, DIRECTOR, SASHA BRUCE YOUTH WORK, INC., WASHINGTON, D.C.

Ms. SHORE. Thank you for the opportunity to testify before the select committee. My name is Deborah Shore and I am the director

of Sasha Bruce Youthwork, which is a multifaceted youth program working with troubled teenagers in the District of Columbia.

I have come before you to share my thoughts about the plight of runaway youth and the services available to them. The young people who become runaways in our country represent the gamut of our society: The rich, the poor, the abused, and the pampered. There is no one prototype or set of characteristics, but rather a representation of the diversity of our society.

Certainly, we can say that youth who run away from home do so because of family problems, often compounded by school, peer, and emotional problems. The runaway experience for some youth is a brief episode and for others, it becomes a way of life. The outcome of the runaway experience for the youth and their family depends upon the health of the family and upon the response of the police, social welfare agencies, and other helpers.

At Sasha Bruce Youthwork, we see approximately 350 youth a year through our runaway effort. We see 75 to 80 percent of our youth from the District of Columbia itself, and also work with 15 to 20 percent who come from Maryland and Virginia and as far away as California.

An important distinction among our young clients, especially for its implications for programing, is the distinction between runaway youth and homeless youth. Approximately 70 percent of our population come to our runaway shelter, and with our aid, return home to an improved family situation or to a relative or family friend.

About 30 percent of our youth are without families to return to, either because they literally no longer have a functioning parent or guardian or because their former guardian is refusing to continue to take responsibility for providing for the child. These situations include youth whose parents have died, those who come from severely alcoholic or drug-addicted families, from families where the entire family has become homeless and the teenager is asked to fend for themselves, and/or where the emotional alienation is such that the youth was asked to leave, usually in anger.

It is with this population of youth that our major problems lie. Those youth who are homeless but who have not committed a crime are completely without institutional resources that will provide them a place to grow up. It is a harsh reality that at least in our jurisdiction, youth who get caught for committing a crime have a wealth of services available to them, as compared to those who are made homeless through no fault of their own.

Unfortunately, without effective intervention, many homeless youth will soon be picked up and brought into the juvenile or criminal justice systems as they commit crimes to stay alive on the streets.

Our organization has two program responses to the problems of runaway youth: We provide outreach to youth who are on the streets through Zocalo Outreach; and we also operate the Sasha Bruce House, which is a short-term shelter.

The first step in the intake process to the Sasha Bruce House is to discuss the youth's situation and to orient them to the rules and regulations of the shelter. One of the important rules is that we must receive permission for the young person to stay from their

family within 72 hours. In fact, 99 percent of the youth call their families within 24 hours for permission.

It is at this first contact with the family that a family counseling session is usually established. The involvement of the families in our service is a critical piece of the work that we do. Our approach is that we explain the program and that we need the parents' aid if we are to truly help their young person. It is they who are the experts about their child.

Making the parents the experts often goes against the position that they are feeling. They feel inexpert, incompetent, as if they have failed. We know that they have not failed, but rather need to learn new ways of dealing with their child, of creating expectations for their young person, and often of structuring things so that their child can succeed.

We find that many parents of our clients do not communicate clear expectations and their young people, therefore, continually feel as if they are not good enough. We also find many young people not carrying their weight at home. We find ourselves often working, helping parents to have their young people learn to do the dishes at home, with sanctions if they don't, and rewards if they do.

Our staff are trained in family counseling and they have regular supervision to insure we are doing the best job that we can with each family.

We are very grateful that we will be able to continue to expand our family counseling efforts through the award of one of the OHDS discretionary grants. Through this grant, we will work with multiple family groups helping those groups of families, after a period of time where our staff work with them, to continue to meet on a self-help basis.

This hopefully will develop into a demonstration which we will be able to disseminate to other runaway shelters throughout the country.

In addition to family services at our shelter, youth are provided individual counseling, group counseling, school advocacy, remedial aid, and any referral needed.

Parallel to our work with families, we create expectations in the community of youth who live at the Sasha Bruce House. Everyone is responsible for chores, for going to school or work each day, for participating in our in-house remedial education program, and tutoring after school, for participating actively in counseling and for participating in the nightly house groups.

As I mentioned earlier, the vast majority of our youth return home or to a stable family-like living situation and typically within 2 weeks. I cannot emphasize strongly enough, however, how serious a gap there is in services to our homeless population. We see dramatic cases every week of youth who have been living in an abandoned car or building for sometimes 6 months before coming to us in rags and hungry.

We will often help youth who are homeless to set themselves up into an independent household. However, this is only possible when the youth is able to obtain a job and has the emotional maturity to live alone. For other homeless youth, we have been able to place

them at Job Corps, but often slots stay full for months at a time there.

We have found volunteer foster families for young people who don't require payment. We sometimes try to involve these young people in the Protective Services System that is primarily set up for neglected youth. We have had a lot of resistance to—at least in our jurisdiction—seeing teenagers as being neglected.

Typically young people coming into the neglect system do so under the age of 2, and so teenagers are not generally viewed as being neglected.

Sasha Bruce Youthwork has a 96-percent, positive placement rate for our youth after shelter. The other 4 percent are youth who are homeless and who continue to run.

Runaway and homeless youth are an at-risk population. They are at risk of becoming severely emotionally damaged; they are at risk of being exploited on the streets, and, of course, also at risk of learning to successfully exploit others.

Sasha Bruce Youthwork, out of concern for this population, has launched a larger outreach effort to seek out youth at an early point before the damage to them is too great. We are regularly working at the downtown bus stations and the 14th Street corridor at a number of youth hangouts in the Washington, D.C., area.

The youth we are finding can be placed at the Sasha Bruce House, but, of course, the long-term solutions are still desperately limited. We are very pleased with our relationship with the local police department and the positive directions that they are taking. However, it is still true that young people who are living on park benches in our city are not picked up by the police. They are left to sometimes go into the adult population in the homeless shelters. We don't know what happens to an awful lot of those young people.

Runaway shelters are an important part of the road to the security for those young people, but we have no resources beyond our short-term mission. I want to mention funding for runaway programs. Our center receives only 15 percent of its funding from the Federal Government through the Runaway and Homeless Youth Act. However, those Federal funds are critical to our existence.

First, we were able to get started as a result of Federal funds, which I am not sure we could have otherwise. Also, we can now leverage other funds because of the Federal backing. Providing Federal support makes sense, not only in that the program is intrastate, but also it insures services to a vulnerable but not particularly popular group of young citizens.

I want to make a special point of thanking those members responsible for helping to double the appropriation of the Runaway and Homeless Youth Act. Unfortunately, many of them are not here to hear that, but it is greatly appreciated by, I know, all of the runaway centers throughout the country.

The runaway program nationally is an extremely cost-effective program with the Federal dollars accessing many millions in private funds in behalf of troubled youth and families and providing unduplicated services.

We interact regularly with other runaway shelters in the metropolitan area and know that our service, as well as theirs, are really

unique in our individual context and in the role that they play in the youth service system.

Nationally, we are an active member of the National Youthwork Alliance. Several of our staff were pleased and encouraged by Congressman Marriott's recent speech at the alliance annual conference in Chicago. We work closely with Chicago's National Runaway Switchboard.

I say all of this to say how important it is to keep alive a coherent national runaway program, and each of those pieces is an important part of that program.

There is no other service to the population of clients we are serving that does not require that you fit into a strictly defined category before the service is available. Runaway centers throughout the country serve as an intake point for youth and link appropriate youth services to those youth before more serious acting out occurs, before the suicide attempt or the delinquent act.

We serve as a prevention service, not just identifying problems, but working at an early point with youth and families that are likely to become more troubled and more troubling.

For these and many reasons, I want to urge the select committee and its members of both parties to make the reauthorization of the Juvenile Justice Act, including the removal of juveniles from adult jails, and the deinstitutionalization of status offenders, one of Congress top family and youth priorities.

I also want to say that I hope that this kind of hearing will help to move the issue beyond crisis intervention because the issue is that perhaps we are able now, more than 10 years ago certainly, to respond to many of the crises, but we have to move beyond the crisis and work with the young people beyond that point.

Thank you.

[Prepared statement of Deborah Shore follows:]

PREPARED STATEMENT OF DEBORAH SHORE, EXECUTIVE DIRECTOR OF SASHA BRUCE YOUTHWORK, INC.

Thank you for the opportunity to testify before the Select Committee. My name is Deborah Shore and I am Director of Sasha Bruce Youthwork, a Washington D.C. based multi-faceted youth program working with troubled teenagers and their families. We are a private non-profit agency with funding from Youth Development Bureau, United Way, private contributions and foundations and from the District Government. We have an overall budget of 1 million dollars.

I have come before you to share my thoughts about the plight of runaway youth and the services available to them gathered through 12 years of personal experience in youthwork. My first job in youthwork was as a streetworker and in-house counselor to runaways. Services to runaways have been a major focus of my work since then and it is a subject which I feel well qualified to address.

The young people who become runaways in our Country represent the gamut of our society, "the rich, the poor, the abused and the pampered." There is no one prototype or set of characteristics but rather a representation of the diversity of our society. Certainly we can say that youth who runaway from home do so because of family problems often compounded by school, peer and emotional problems. The runaway experience for some youth is a brief episode and for others becomes a way of life. The outcome of the runaway experience for the youth and for their families depends upon the health of the family, and the response from the police social welfare agencies and other helpers.

At the Sasha Bruce House, we see approximately 350 youth a year through our runaway effort. Of these, 49 percent are males and 51 percent are females. 83 percent of our clients are black, 15 percent are white and 3 percent are Hispanics. Average age is 15. We see 75–80 percent of our youth from the District of Columbia but also work 15–20 percent who come from Maryland and Virginia and also as far

away as California. In the past year, we have seen a 3–5 percent increase in youth coming to our residence from long distances.

Sasha Bruce House client statistics are not exactly representative of the national client profile but reflect the youth population of our area.

An important distinction among our young clients for its implications for programming, is the distinction between runaway youth and homeless youth. Approximately 70 percent of our population come to our runaway shelter and with our aid can return home to an improved family situation or to a relative or family friend. About 30 percent of our youth are without families to return to either because they literally no longer have a functioning parent or guardian or because their former guardian is refusing to continue to take responsibility for providing for the child. These situations include youth whose parents have died, those who come from severely alcoholic or drug addicted families, from families where the entire family has become homeless and the teenager is asked to fend for themselves and/or where the emotional alienation is such that the youth was asked usually in anger, to leave home. It is with this population of youth that our major problems lie. Those youth who are homeless but have not committed a crime are completely without institutional resources that will provide them a place to grow up. It is a harsh reality that at least in our jurisdiction, youth who get caught for committing a crime have a wealth of services available to them as compared to those who are made homeless through no fault of their own. Unfortunately without effective intervention many homeless youth will soon be picked up and brought into juvenile or criminal justice system as they commit crimes to stay alive on the streets.

Our organization provides two program responses to the problems of runaway youth. We provide outreach to youth who are on the streets through Zocalo Outreach soon to be located in Georgetown's Dumbarton Methodist Church and near Dupont Circle and we operate the Sasha Bruce House, a short term shelter home on Capital Hill in N.E. Washington. Young people can come to our runaway shelter at any time of the day or night. The first step in the intake process is to discuss the youth's situation and to orient them to the rules and regulations of the shelter. One of the important rules is that we must receive permission for shelter from their family within 72 hours. 99 percent of our youth call their families within 24 hours. It is this first contact with the family that a counseling session is usually established. Each youth is assigned a primary counselor. This counselor provides family counseling to each of their clients as well as all of the other services we provide including aftercare.

The involvement of the families in our services is a critical piece of the work we do. Because we see the young people initially, the families are often suspicious that we will take the young person's side in what has often been a long standing family battle. Our approach is that we explain the program and that we need their aid if we are to truly help their youth. It is they who are the experts about their child. Making the parents the experts goes against their feeling . . . inexpert, incompetent, as if they have failed. We know they have not failed but rather need to learn new ways of dealing with their child, of creating expectations for their young person and often of structuring things so their child can succeed. We find many parents of our clients do not communicate clear expectations and their young people feel continually as if they are not good enough. We also find many young people not carrying their weight at home. We find ourselves working often on helping the parent to get their child to, for instance, do the dishes with sanctions if she doesn't and rewards if she does. Our staff are trained in family counseling and they have regular supervision to insure that we are doing the best job we can with each family.

We were awarded one of the OHDS discretionary grants. Through this grant we will collaborate with the Family Therapy Practice Center and Marianne Walters in working with groups of families initially in treatment who then will become self-help and self-directed groups. This is a new model for service and we are very grateful for the opportunity to develop this demonstration project.

In addition to family services, youth are provided individual counseling, group counseling, school advocacy, remedial aid and any referral needed.

Our staff often visit the young person's school and help improve the learning environment there.

We arrange for educational testing if needed and for remedial tutoring as well.

Parallel to our work with families, we create expectations in the community of youth who live at the Sasha Bruce House. Everyone is responsible for chores, for going to school or work each day, for participating in our in-house remedial education and tutoring program after school, and for participating actively in counseling, for being at dinner on time and for participating in the nightly house groups. We are currently working on upgrading our afterschool program because we have found

that the vast majority of our youth are 2-3 grades behind in school and have often been chronically truant before entering the program. Sasha Bruce house is a structured program where youth are provided intensive services to resolve their immediate problems and where we lay the groundwork for continuing to work on the underlying problems which brought them to the point of leaving home.

As mentioned earlier, the vast majority of youth return home or to a stable family like living situation and typically within two weeks. However, it is those youth who are homeless for whom much more time in residence and creative solution to their homelessness is required. I cannot emphasize strongly enough how serious a gap in services there is for our homeless youth. We see dramatic cases every week of youth who have been living in an abandoned car or building for sometimes six months before coming to us in rags and hungry. We will often help youth to set up an independent household. This is only possible however when the youth is able to obtain a job with a decent wage and has the emotional maturity to live alone. We have utilized Job Corps in the past but have recently found that most slots are full and stay full for months at a time. We have on occasion been successful in placing these youth with volunteer foster families who do not require payment. We will sometimes involve Protective Services but have found a resistance to viewing teenagers as neglected. The usual new client to this system is under the age of 2. Sasha Bruce Youthwork has a 96 percent placement rate for our youth after shelter. The other 4 percent are youth who are homeless and who continue to run. Most eventually land in the criminal justice system or in mental institutions.

Runaway and homeless youth are an at risk population . . . they are at risk of becoming severely emotionally damaged, they are at risk of being exploited on the streets and of course also at risk of learning to successfully exploit others. Sasha Bruce Youthwork, out of concern for this population, has launched a larger outreach effort to seek out youth at an earlier point before the damage to them is too great. We are regularly working at the downtown bus stations, in the 14th Street corridor, and at two youth hangouts in Northeast, Washington. The youth we are finding can be placed at the Sasha Bruce House but of course the long term solutions are still desperately limited. We are pleased with our relationship with our local Police Youth Division and the positive directions they are taking. I am concerned however that youth who are living on the streets are not picked up at this point even understanding the police concerns for suits of false arrest. Homeless youth need special services to help them grow up in a stable environment. Runaway shelters are part of the road to security but we have no resources beyond our short term mission.

I want to mention funding for runaway programs. Our center receives only 15% of its funding for runaway services from the Federal government in Runaway and Homeless Youth Act. However, those federal funds are crucial to our existence. First, we were able to get started as a result of federal funds from the National Institute of Alcohol Abuse and Alcoholism. Also, we can now leverage other funds because of the federal backing. Providing federal support makes sense not only in that the problem is intra-state but also in that it insures services to a vulnerable but not particularly popular group of young citizen.

I want to make a special point of thanking those members responsible for helping to double the appropriation for the Runaway and Homeless Youth Act this past year. The increases to old centers and the addition of more services are very important. The Runaway Program is an extremely cost effective program with the federal dollars accessing many millions in private funds in behalf of troubled youth and families and providing unduplicated services.

Additionally, I want to say that we interact with other runaway shelters in the metropolitan area especially and feel confident that those shelters as well as our service is truly unique in our individual contexts. Nationally we are an active member of the National Youth Work Alliance. Several of our staff were pleased and encouraged by Congressman Marriott's recent speech at the Alliance annual conference in Chicago. We also work closely with Chicago's National Runaway Switch board.

There is no other service to the population of clients we are serving that does not require that you fit into a strictly defined category before the service is available. Runaway centers throughout the country serve as an intake point for youth and link appropriate services before more serious acting out occurs, before the suicide attempt or the delinquent act. We serve as a prevention service not just identifying problems but working at an early point with youth and with families that are likely to become more troubled and more troubling without effective intervention.

For these and many reasons, I also want to urge the Select Committee and its members of both parties to make the reauthorization of the Juvenile Justice Act,

including the removal of juveniles from adult jails and the deinstitutionalization of status offender one of Congress top family and youth priorities.

Thank you.

Mr. FISH [presiding]. Thank you very much, Ms. Shore.

As the chairwoman said earlier, we have to leave this room at 2, which leaves us about 17, 18 minutes for the remaining 3 witnesses. We do want to hear from all of you.

Your statements will become a part of the record and I would appreciate it if you could attempt to summarize in the space of 5 or 6 minutes. It gives me great pleasure at this time to introduce a fellow New Yorker, Mr. Joseph Covino, library director, Great Neck Library, Great Neck, N.Y.

STATEMENT OF JOSEPH COVINO, LIBRARY DIRECTOR, GREAT NECK LIBRARY, GREAT NECK, N.Y., ACCOMPANIED BY DANNY SONENBERG

Mr. COVINO. OK, I will cut this out completely.

Essentially, the youth facility was established because a lot of young people came to the library when we opened up our new building and we wished to do something positive with them. We opened a facility within the building totally supported by the library budget. There is free bus service 5 days a week to bring the kids there, open to midnights on Friday and Saturdays; works on the basis that young people must be respected, must be given independence; and for a youth facility to really work properly, you must take risks in terms of trusting them in what they wish to do.

They choose the programs; they manage the programs. We use theater a great deal. We average 8 to 10 theatrical productions annually and they do it all: cast, direct, scenery, music. It is a great learning experience for young people of different age levels to learn how to work together and see what they can accomplish.

The facility serves the seventh grade through high school. We have many people who have gone on to college who return back to help out. A steady core of perhaps 250 users, another 200 occasional users, and I wish more places were in a position to have facilities like we could afford to do.

Mr. FISH. I am sending your testimony to the librarians—the president of the board of libraries in cities in my district.

Mr. COVINO. I think Danny has a truer picture of what a place like Levels is about.

[Prepared statement of Joseph Covino follows:]

PREPARED STATEMENT OF JOSEPH COVINO, LIBRARY DIRECTOR, GREAT NECK LIBRARY, GREAT NECK, N.Y.

Levels is a very special and unique youth facility, a cultural center and meeting place for junior high and senior high people and an integral part of the Great Neck Library.

Located in a suburban Long Island community just east of New York City, the Great Neck Library serves a population of approximately 48,000 residents. Known as a wealthy, highly educated and unusually sophisticated community with extensive educational and recreational facilities, it also has a large and growing black, hispanic, Iranian, and Asiatic population. Possessing the largest complex of apartments in Long Island, it also has a growing population of elderly and single parent families.

The story of Levels—how it developed, how it functions and what it does—is also the story of how a library and a community, especially its young people can work together to create something which is truly their own.

When the new main library opened in 1970 it immediately attracted large numbers of the community's teen-age population, who not only found it an attractive place to study but also a very desirable place to meet friends and talk. There were no other facilities open evenings where young people could congregate; their only other alternatives were street corners or luncheonettes. The library committeed to creating an environment in which all people would feel welcome and at ease, worked especially hard to develop a positive image among the young people, many of whom were turned off by institutions not responsive to their needs.

In order to make our facilities more easily accessible, a free bus service running regularly scheduled routes five days a week, was instituted. Its routes included Great Neck's black areas, where it was highly successful in attracting young people to the library.

Faced with the increasingly large number of young people who were using the library more and more as a social center and placing pressures on the more traditional functions of the library, it was decided to explore positive alternatives. An advisory committee composed of both adults and young people recommended that the library establish a youth facility within the parameters of the new building. A large portion of the lower level has been left unfinished to provide for future expansion, the approximately 3,500 square feet of this area was allotted to the youth facility.

An architectural design concept was developed to create a feeling of openess and freedom whereby teenagers would not feel stifled, and to provide a variety of intimate areas for small groups or individuals, a series of elevated multi-leveled pits, separated by low walls with carpeted steps for seating, and a central area featuring a stage surrounded by a large area of floor space and more carpeted steps for additional seating was developed. These architectural features led the young people to choose "Levels" as the name of the facility. Rest rooms brightly colored, walls and carpets, spotlights and flourescent strips, a central sound systems, stage lighting, a piano, and a canteen area with vending machines were added. The facility was designed to function without furniture, breakable or otherwise.

Although Levels is accessible through the library, a separate outside entrance was provided, which allowed the facility to be open when the library is closed. Its present hours of service are 3:00 to 10:00 p.m. Monday through Wednesday, 6:00 p.m. to midnight on Friday, and 3:00 p.m. to midnight on Saturday.

Levels is run as a semi-independent department of the library, with its own staff of two full-time and several part-time youth workers, who usually have professional experience also as artists, dancers, musicians, etc. New staff is chosen by a committee composed of several young people, the Library Director, and other Levels staff members. A planning council composed of the young users of the facility suggests and approves the programs and activities which take place in Levels. The users carry much of the responsibility of handling and minimizing such problems as drug and alcohol use disorders within the facility and have been very successful. Vandalism is almost non-existent. Users who have been disciplined by staff have a right to a hearing before a "peer-court".

Levels is completely funded by the library budget, which is voted upon annually by the community. The budget has always been approved, this year by a four to one margin. The personnel and programming costs of Levels are approximately $100,000 annually. There is no charge for any of the programs and services provided in Levels, including the bus service. All performers in Levels' groups and musical groups, must perform on a voluntary and free basis. We cannot handle the large numbers of groups which wish to do so.

"Organized" activities at Levels are usually of three types: workshops, weekend events, and theatrical productions.

Workshops have included music classes (guitar, banjo, voice, etc.) crafts (painting, pottery, macrame, jewelry design, weaving, etc.) humanities (creative writing, playwriting, comic book art, science fiction, book discussions), as well as yoga, dance, modeling and computer programming on the facility's two Apple computers. The classes are usually conducted on weekday afternoons by staff members or "peer" teachers, young people who are especially skilled in certain areas.

Week-end events take many forms and invariably include some kind of live music or entertainment, such as local rock, jazz or other musical groups and variety shows created by budding young entertainers Films are frequently shown.

Levels has an average of eight to ten theatrical productions a year which are open to the public and attract capacity audiences (about 175). The many productions have

included Equis, Hair, Jesus Christ Superstar, The Three Penny Opera, and plays by Beckett, Miller, Williams, etc. Plays written by the Theatre Workshop members are also produced. Theatre is used as a means of teaching many diverse young people how to work together, and the participants handle all phases of the production, including direction, casting, staging, sound, lighting, music, and publicity. Television workshops are also given and Levels has its own programs on the library's Cable TV channel.

The most valuable activity in Levels is probably the interaction which takes place among the young people and with staff. Critical to this interaction is the feeling of respect and warmth which permeates Levels. Problems are discussed, and ideas and opinions are exchanged in a free and open atmosphere. It is the staff's responsibility to create a personal place-to get to know the kids, what their interests and concerns are, and to facilitate their participation as an extension of themselves. Levels is especially successful in involving young people who had not previously participated in social activities. The "soft-sell" approach by staff is highly effective.

The hard-core group of users of Levels number between two hundred and two hundred and fifty, an equal number are occasional users, and others come for special weekend events.

In its ten years of existence Levels has established itself as the one place in the community where young people from a wide variety of backgrounds and ages have been able to meet, to learn from each other and work together. They, many times are astounded by what they could accomplish. Given the atmosphere of trust, respect, and independence, they have flourished. Thousands of users have attained adulthood, and many return to visit and help. Critical to the success of Levels has been a dedicated and caring staff, led by Ed Amrhein, who had been its Director for nine and one half years before his untimely death four months ago.

Levels has shown that it is possible, given the desire and understanding, for a community to work positively and productively with its young people. Great Neck is fortunate that it possesses the resources to have a Levels; we hope that other communities will be given the resources to duplicate our program.

Master SONENBERG. My name is Danny Sonenberg. I am 13 years old and currently in the eighth grade at the Great Neck North Middle School, which is in New York.

I first became interested in Levels about 3 years ago when my older sister was involved with the Theatre Workshop Players there. I attended all of the performances she was in, and I slowly began to look forward to the time when I would be old enough to join. I was in the sixth grade then and too young to meet the age requirement, which is between the seventh grade and the end of college.

By the time I reached the seventh grade, I was going through a very difficult time in my life because my father had died the year before and I didn't have very many friends in school. When I attended the first meeting of the Theatre Workshop Players, I was overwhelmed by how friendly the kids and the Levels staff were. It was a new experience for me to have people go out of their way just to become friendly with me.

I also had a chance to meet people who were older than I with more experience in the theater and they were certainly willing to help me.

Anyone who wants a part in the Theatre Workshop Players production can have one, but when all of Levels staged a musical, you had to audition. Only 1 month after I started going to Levels, I auditioned for a musical and actually got a part. Slowly I began to go to Levels more often, whether it was just for a rehearsal or to be there to have fun and do some of the other things Levels had to offer.

In a few months, I found myself involved with the computer program Levels has, which is run basically by kids familiar with the computers. I soon became a manager of the computer area and

found that not only was I being guided by the older kids, but I was helping other boys and girls besides, and making a lot of new friends.

The good thing about making friends at Levels is that they are often not your own age, but they all share at least some of your interests.

My sister, being in the 11th grade, had to start worrying about SAT's and visiting colleges so she had very little time for me or Levels. Even my mother, as close as we were, didn't have actually that much time to spend with me. I wanted to be with people I could talk to and spend a little time with.

If I ever had a problem with a teacher in school or anything related, I sometimes felt better talking to kids who had gone through the same academic program I had and asking them how they handle similar problems. I also felt very comfortable talking with the Levels staff members about these problems. I found them always willing to help me, and they treated me as an equal, unlike school teachers, and even guidance counselors sometimes.

In this past year, I have had the opportunity to write and direct a play for the Theatre Workshop Players. This really gave me some confidence in myself and made me feel very good. I never felt anything like the thrill of people enjoying and laughing at a play I wrote.

People started realizing that I was my own individual; instead of being Nina's brother, I became Danny. Because of this, people began to have a more positive reaction to me.

In late May of this year, my sister and I and all of the people who participate in Levels experienced a tragedy. The director of Levels, a young man for whom everybody felt a great affection, died in a way very similar to that of my father. The day after this happened, a very large group of kids, ranging in age, came to Levels for the sole purpose of being with other people who felt like themselves and to express their feelings.

It was like nothing I had ever seen before. We were all together like a family and we were all working together. It was the first time in my life that I had expressed feelings and deep emotions to people my own age. I feel as though I have learned a lot from this experience.

Remarkably, the director's death did not cause Levels to fall apart. We all worked together to keep Levels alive and got right back on our feet.

This is what I feel toward and about Levels. It means there is always a place for me to go where I will be welcome and feel good about myself. I hope this type of experience can be shared by other people my own age and I just want to thank everyone for letting me speak here, and thank Joe.

Mrs. BOGGS [presiding]. Danny, thank you so much. I am sorry that I had to miss a part of your spoken testimony, but I have read your testimony and I am so pleased that you are here.

Perhaps some of the other people from Levels who are in the room would stand up and identify themselves.

DAVID. I am David.

Mrs. BOGGS. David.

ADAM. Adam.

Mrs. BOGGS. Adam.
ABBY. Abby.
Mrs. BOGGS. Abby.
TOM. Tom.
Mrs. BOGGS. Tom. And are all of you in the program?
[Chorus of yeses.]
Mrs. BOGGS. Do you agree with Danny that it is a great program?
[Chorus of yeses.]
Mrs. BOGGS. Let's hear it for the program, OK. [Applause.]

Thank all of you for making the trip here and thank the directors and the parents and everyone who made it possible. We are really quite proud of all that you are doing. This committee was established to hear your points of view, work out some of the problems, and also to help you reach the great potential that each of you has. So we need your testimony very, very seriously. We are very grateful to you for giving it to us.

We will go on with the other witnesses. Mr. Stewart, who is the Director of Center 54 of the Rheedlen Foundation in New York City, is accompanied by Victor Marte.

It is so nice that you are here, Victor.

STATEMENT OF JOSEPH STEWART, DIRECTOR, CENTER 54, RHEEDLEN FOUNDATION, NEW YORK CITY, ACCOMPANIED BY VICTOR MARTE

Mr. STEWART. Thank you.

Center 54 is a project of Rheedlen Foundation. It is open to young people 12 years old to 21 years old. It is a consortium effort of community-based agencies. The center offers tutoring, referral services, structured recreational alternatives to the street, counseling, health screening, high school equivalency examination prepping, and bilingual classes.

On the average day, a young person will leave Junior High School 54 at one door and enter the center through another. They enter to do their homework, socialize, and/or to use the gym. On the same day, young people who are not in school will also come to the center.

There is nothing exceptional about the kinds of services that we offer. I am not going to sit here and tell you that Center 54 has discovered some magical words to counsel the average 15-year-old adolescent to do the things we think they should be doing, nor does Center 54 have a foolproof method for delivering reading or improving math or reading abilities.

Yet, I believe the center, though modest in size, is worth looking at because of its ability to engage adolescent youth in positive and structured alternatives to the street during nonschool hours.

In the course of an average week, 300 individual youth will walk through our doors. It cost a minimal $50,000 to keep the center open 8 months out of 1 year and be aware that out of the 50,000, 20,000 is allocated for rental of space.

For today's discussion, I am going to highlight what I consider some of the factors, unique factors I and others have pointed out about Center 54.

First, the center is located in Junior High School 54. It is located in the community of Manhattan between Manhattan Valley, Columbia University, and Harlem communities. While the surrounding area is fighting a losing battle with gentrification, Center 54's immediate neighborhood is a negative oasis of drugs, poverty and youth unemployment.

Although too often schools are viewed by the community as a place where children have to go and parents must go when their children are in trouble, ironically, the school is the most secure and suitable building for youth and their parents to gather. There is adequate space, heat and lighting.

Over the past 4 years, Center 54 has succeeded in bringing many agencies into the space so that we can offer a variety of services. This includes the board of education's own adult bilingual program, which could not operate if the center wasn't paying the rent and security fees.

Thus, the school is not only seen as a place you have to go to, but a place you choose to go to. For many youth who live in overcrowed and inadequate housing, the center becomes their "living room" where they can interact with their peers in a supervised and structured environment.

Second, the physical environment. The second factor I wish to stress, that there is the physical aspect of the school building. Most school buildings, and 54 is no exception, are eggcrate in shape and painted in safe institutional green. During the past summer, we decided to renovate one wing of the building. We sanded the floors, scraped the walls and painted them white, white walls in the classrooms and in the hallways, against the advice of almost everyone. Yet, a year and a half later, we find that our once peagreen soup walls are still white and without one mark.

Third, our reading tests. Everyone who registers at the center must take the reading test. It is a wide-range achievement test. Whether you are in school or out of school, in the seventh grade or in college, you must take this test. On the basis of the test, our educational staff will assess a person's reading ability and refer them, if they need referral, to either the GED program or to spend time in our learning center.

Obviously, with our budget, we cannot tutor 300 youth, but we can identify the ones who need appropriate resources and guide them to it. I am so serious about this that I have closed the gym on our busiest nights and dragged youth bigger than myself to take the test.

Fourth, we have membership cards. All those who use the center must register and must present the card before they enter. Previously, youth were allowed to come and go as they please. They felt that only the school and other "negative" places demanded, you know, such strict requirements, but now they realize that if they want a safe place to meet their friends, they must submit to certain procedures. The same procedure is part of the real world; it asks me to present a Columbia alumni card if I want to use their facilities.

The fifth thing is the relief of racial tension. At Center 54, while friendships are maintained and formed, the relationships between groups can be strained. We have cliques of different teenagers, Hai-

tians, Puerto Ricans, Domincans, and blacks bringing their hostilities, their social hostilities into the building. For instance, we had—baskets in the gym used to be turf areas, one for Dominicans, one for Puerto Ricans, one for blacks.

One of the first things I did was to change that and through team sports integrated the gym. I decided that mentality of again having cliques at each center was a negative and we decided to go with—the only basket that is going to be segregated is the one that we demand be left open to the girls, since they have to have a place and since the center has been predominantly male, we try to specifically engage females, so we leave baskets open to them.

Because of this racial harmony, parents of females feel confident that they could let their daughters stay in the center without anything happening.

The five factors that I just talked about make the center a place where youth want to come in to work and it makes my staff feel challenged to return in the year.

There are some things that the center is not and should be. I would like to take 1 minute to list three deficiencies.

First, the center is not open 12 months a year, 7 days a week until midnight. The community need, however, is there.

Second, there is no access to computers where the young and their parents can learn and keep up with technology. Such learning would and could take place late into the evening if machineries and staff were available.

Third, there is not sufficient athletic space to encourage more coed recreational activities. If we are to reduce the rise in teenage pregnancy, we must form more coed programs.

I could go on with what the center needs, but in good taste, I should stop. The reason I come here—first of all, I like to speak about my work; I love my work, and second is more mercenary. Hopefully, what I and other people say today can result in the not too distant future of securing funds and programs such as Center 54 and other programs that deal with adolescent problems. It should be automatic to fund them, rather than having to go through this procedure year in and year out.

It is a good attempt to help the 15-year-old before he drops out of school and before he gets on drugs and before he is already a parent, he or she. In the long run, programs like Center 54 cost much less in dollars and human suffering.

Thank you.

[Prepared statement of Joseph A. Stewart follows:]

PREPARED STATEMENT OF JOSEPH A. STEWART, DIRECTOR, CENTER 54, NEW YORK, NEW YORK

Good Morning: Center 54, a program of the Rheedlen Foundation, is open to all young people ages 10–21. Here, through a consortium of community-based agencies, the Center offers an after-school program four days a week that includes tutoring, referral services, structured recreational alternatives to the street, counseling, health screening, high school equivalency examination prepping, and bilingual classes. On an average day, a young person will leave J.H.S. 54 at one door and enter our center at another door to do their homework, socialize, or use the gym. On that same day, young people who were not in school will also come into the Center.

There is nothing that exceptional about the kind of services we offer. I am not here to tell you the Center has discovered the magic words to counsel the average 15 year old adolescent to do what we think and know they should be doing. Nor has

Center 54 discovered a foolproof method to improve reading or math abilities. Yet, I believe Center 54, though modest in size, is worth looking at because of its ability to engage adolescent youth in positive and structured activities in non-school hours. In the course of an average week, over 300 individual youth will walk through our doors. The cost is minimal: $50,000 to keep open eight months a year. And be aware, of that $50,000, $20,000 is allocated for the rental of space.

For today's discussion, I am going to highlight what I consider some of the unique factors I and others have identified about Center 54:

1. LOCATION

The Center is located in Junior High School 54, which is located in the Upper West Side of Manhattan including Manhattan Valley, Columbia University, and the Harlem Communities. While the surrounding area is fighting a losing battle with gentrification, Center 54's immediate neighborhood is a negative oasis of drugs, poverty, and youth unemployment. Although too often the school is viewed by the community as a place children have to go to and parents must go to when their children are in trouble, ironically the school is the most secure and suitable building for youth and their parents to gather. There is adequate space, heat and lighting. Over the past four years, Center 54 has succeeded in bringing many agencies into the space so that there can be a variety of services. This includes the Board of Education's own Adult Bilingual Program, which could not operate if the Center were not paying the rent and security fees. Thus, now the school is not only seen as the place you have to go, but a place you choose to go to. For many youth who live in overcrowded and inadequate housing, the Center becomes their "living room" where they can see and interact with their peers in a supervised and structured environment.

2. PHYSICAL ENVIRONMENT

The second factor I wish to stress is the physical environment of our space. Although most school buildings are built for the ages, they—and J.H.S. 54 is no exception—are often eggcrate in shape and painted in safe institutional greens. The summer before last, we decided to renovate one wing of the school. We sanded the floors, scraped the walls and painted them white. Yes, white walls both in the classroom and hallways. This was against the advice of almost everyone. A year and a half later finds these once pea soup green walls still white and without one mark. Enough said.

3. READING TESTS

Every youth who registers for the Center must take a short reading test. There are no exceptions . . . whether you're in school or out of school, in the 7th grade or in college, you must take the test. On the basis of that test, our educational staff will assess whether or not the person is reading at grade level, and, if help is needed, develop a plan of action. Obviously on our budget we cannot tutor 300 youth, but we can identify those who need it and make available appropriate resources. We are so serious about this that I have closed the gym on our busiest nights to drag youth, bigger than myself, dripping with sweat, to take their test.

4. MEMBERSHIP CARDS

All youth must register for the Center and present their card when they enter. Previously, all youth were allowed to come and go as they pleased. Whereas all youth felt that only school and other alleged "negative" places required such regulation, youth now realize that if they want a safe place to meet their friends, they had to submit to certain procedures. Procedures that are part of the real world . . . and the same procedures asked of me if I want to use Columbia's Alumni Club.

5. RELIEF OF RACIAL TENSION

At Center 54, while friendships within groups are formed and maintained, relationships among groups can be strained. Cliques of teenagers—Haitians, Puerto Ricans, Blacks—bring their social hostility into the building. For instance, the baskets in the gym were turf areas, one for the Dominicans, one for the Haitians, one for the Puerto Ricans. I decided to change this mentality through team sports and integration of the gym. Now only the mandated girls' basket is segregated—not by race, but by sex; the other three are open to everyone. While membership initially decreased as a result of the integration of the gym, I count it as my proudest accom-

plishment. It represents a personal victory translated into policy that agrees with the values of the program. Because of this racial harmony, parents—especially parents of adolescent females—feel confident in letting their daughters come to the Center.

The five factors I have talked about are some of the reasons, in my opinion, that make Center 54 a place where youth want to come and I and my staff feel challenged and want to return to year after year.

Yet, there are many things the Center is not and should be. I'd like to take a minute to list just three deficiencies:

(a) The Center is not open 12 months a year, 7 days a week until midnight. The community need, however, is there.

(b) There is no access to computers where the youth and their parents can keep up with technology. Such learning could and would take place late into the evening if machines and staff were available.

(c) There is not sufficient athletic space (e.g., a swimming pool) to encourage more coed recreational activities. If we are to reduce the rise in teenage pregnancy, more coed programs must be created.

I could go on with what the Center needs, but good taste tells me I should conclude. In summarizing, my reasons for coming today are two-fold:

First, it's nice to be invited to speak on my work. My second reason is more mercenary. I hope from what I and other people have said today that it will result in the not too distant future that the fund of programs like Center 54 will be automatic. Funding programs that serve youth in a positive, preventive manner are more sane than those that only attempt to help a 15 year old who has already dropped out of school, is on drugs, and is already a parent. In the long run, programs like Center 54 cost less . . . both in dollars and human suffering.

I thank you for the opportunity to testify.

Mrs. BOGGS. Thank you very much.

Victor, we would like to hear from you.

STATEMENT OF VICTOR MARTE

Mr. MARTE. I have been involved with Center 54 for the last 4 years and my testimony is based on a brief description of the center and what does it mean to me and other youngsters at the community.

Center 54 is a community center sponsored by Rheedlen. Within the center, there is a variety of activities that youngsters, as well as adults, can get involved in. The center aids the community in many ways and it also brings unity among people of different cultural group backgrounds.

This center offers different activities to the youngsters and adults of the community, such as trips to the museum, outdoor and indoor sports, help for those having difficulties in any academic area. We also have dances and shows as a source of entertainment. Also, the opportunity to share ideas with other youth groups in the community. These are basically the activities that go on in the center.

Center 54 aids the community in many ways. It keeps the youngsters and adults from settling on the streets; helps them get involved with something constructive and from which they can learn. We warn the participants of the dangers of drugs or getting hooked with any sort of crime.

Speakers from different programs come in and talk to those who dropped out of school and inform them how they can obtain their high school diploma. Everyone is treated equally. We strive to see the Latins, blacks, and whites in the center as a clan. These are the reasons why I consider Center 54 as a community helper.

I personally consider Center 54 as my second home. It brings about a positive attitude to the members, and specifically to those who are climbing the ladder of opportunity. It helps you to think in terms of the importance of staying in school and becoming successful. I have taken advantage of what the center has to offer and I have gained a lot.

It protects people from getting involved with drugs, crime, or being a victim of crime. It is a nucleus where ideas can be picked up and put to practice. It makes me contribute as much as I can to improve the society in which I live in today.

It is where discrimination and prejudice is extinct. This is why I believe Center 54 is an influence in my community, and why it is of paramount importance to keep it open throughout the year.

Thank you.

[Prepared statement of Victor Marte follows:]

PREPARED STATEMENT OF VICTOR MARTE, WASHINGTON, D.C.

Center 54 is a community center sponsored by Rheedlen. Within the center, there is a variety of activities that youngsters as well as adults can get involved in. The center aids the community in many ways, and it also brings unity among people of different cultural backgrounds.

This center offers different activities to the youngsters and adults of the community such as trips to the museum, outdoor and indoor sports, help for those having diffculties in any academic area. We also have dances and shows as a source of entertainment; also the opportunity to share ideas with other youth groups. These are basically the activities that go on in the center.

Center 54 also aids the community in many ways. It keeps the youngsters and adults from settling on the street; helps them to get involved with something constructive and from which they can learn. We warn the participants of the danger of drugs or getting hooked with any sort of crime. Speakers from different programs come in and talk to those who dropped out of school and inform them of how they can obtain their high school diploma. Everyone is treated equally. We strive to see the Latins, Blacks and Whites in the center as a clan. These are the reasons I consider Center 54 a community helper.

I personally consider Center 54 as my second home. It brings about a positive attitude to the members, and specifically to those who are climbing the ladder of opportunity. It helps you to think in terms of the importance of staying in school and becoming successful. I have taken advantage of what the center has to offer and I have gained a lot from it. It protects people from getting involved with drugs, crime, or being a victim of crime. It is a nucleus where ideas can be picked up and put to practice. It makes me contribute as much as I can to improve the society in which I live today. It is where discrimination and prejudice is extinct. This is why I believe Center 54 is an influence in my community, and why it is of paramount importance to keep it open throughout the year.

Mrs. BOGGS. Wonderful, Victor. Not only do you recognize the program for what it does for you, but it gives you a social consciousness about what you should do for other people. That is wonderful.

Dr. Novello, you have been so wonderfully patient and those of us on the committee, of course, are familiar with your remarkable work here in Washington. We were so anxious to have you with us and I know you have come at great expense of your time and life and we are really pleased to have you with us.

STATEMENT OF JOSEPH NOVELLO, DIRECTOR, CHILD AND ADOLESCENT SERVICES, PSYCHIATRIC INSTITUTE, WASHINGTON, D.C.

Dr. NOVELLO. Thank you very much, Madam Chairman, distinguished members of the committee, ladies and gentlemen. I feel like the Redskins going into their 2-minute drill. [Laughter.]

Mrs. BOGGS. That is the most important part of the game, Doctor.

Dr. NOVELLO. You are right. If I am half as good as they are at scoring points, maybe I can make a few points.

I am here today as a clinical associate professor at Georgetown University in psychiatry and pediatrics, but primarily in my role as director of the gateway, which is a program for the diagnosis and treatment of teenage drug abusers.

Teenage drug abuse is not a pretty scene. When you stop to think about it, and considering the testimony that went on earlier, teenage drug abuse is probably actually the No. 1 cause of death among adolescents. When you stop to consider that in a recent year, at least 16,000 auto fatalities involving adolescents were drug related. It is estimated that about half of those 5,000 suicides are probably related to drugs. It is not a pretty scene.

In my written testimony, which I hope the committee will receive, I list the 10 most commonly abused drugs and make remarks about both. In the interest of time, I will not do that at this point, only to make a couple of statements.

Alcohol, by far, is the most commonly abused drug among adolescents. It is estimated that about 8 percent of all the teenagers in this country have a serious alcohol problem. That is not a small number. That translates, in my math, to about 1.3 million teenagers in this country.

Marijuana, good news and bad news. The use is going down but still about 8 percent of high school seniors get high on pot every day. It has its own kind of trickle-down effect. We are seeing younger and younger children being introduced to drugs through marijuana in our own programs, sometimes at the age of 10 and 11, and occasionally even younger.

PCP, phencyclidine, is on the rise. I mention that because it is a bad-news story all the way. This is a very dangerous drug. It is a hallucinogen that causes violence and agitation. About 4.9 percent of youngsters right here in the Nation's capital report using it on a weekly basis.

I will say a word or two about cocaine because it is so often assumed that that is the drug of the jet set. Well, the prep set is getting introduced to it also, probably not used as much as it would be only because it is so expensive. There are two dangerous avenues, though, for teenagers to be introduced to cocaine and I am learning, as I work with these youngsters all the time, boys afford cocaine by going into dealing; girls afford cocaine by dealing what they call sex for snow. So the door to cocaine is into the underworld, the sleezy world of crime.

I list the other drugs in my written testimony. What are the causes of teenage drug abuse? I wish I knew. There were many, many causes that I have outlined in my written remarks.

I think you have to start with the nonpsychiatric cause and that is the alarming availability of drugs throughout our Nation. No community, no school, no family, not yours or mine, is invulnerable to drugs.

No. 2, adult modeling. We live, it is sometimes said, in a valium society. Make that Jack Daniels, maybe, for some. Kids look at what we do, not what we say, and when they see us turn to a drink or to a pill to solve a problem, they have a tendency, a strong tendency to imitate and identify.

There is another important problem and that is that it is not often recognized that chemical dependency itself is a disease. As a physician, I have only really evolved to this understanding recently. Most physicians are trained in the traditional way where chemical dependency is seen as a symptom of something else. I have learned that itself is a disease.

These are not bad kids; they don't come from bad, noncaring families; their parents, most of the time, want to do the very best for them. It is a disease. It has its own clinical course. It is progressive; it is chronic; it is fatal if not treated.

There are other causes as well. Some of these youngsters do have psychiatric illness and they turn to drug abuse secondarily, sometimes in an effort to self-medicate: uppers if they are depressed; hallucinogens if their mind is wandering and can't concentrate.

I would like to remark on a couple of other causes, also. There is a kind of philosophy of parenting still abounding, I think, in our country that goes back many years: This kind of permissive school. Based on that kind of loosey-goosey nonphilosophy of "If it feels right, do it, do your own thing; don't suppress a desire; let them invent the wheel for themselves," and as a child psychiatrist, too often I see these youngsters getting run over by that wheel before they ever have a chance to invent it.

Someone has to be in charge of families and I say that that should be mothers and fathers, not scared 13- and 14-year-olds. Now, I am not a hardliner; I like to come down midway, but children do need discipline. They will ask you for it if you give them a chance. They need some guidance. They need some values to come up against in their life.

In defense of parents, I would say that those of us who have an opportunity to do so have too often let them down. They are undereducated about the ravages of teenage drug abuse. They go through a series of steps. There is a step of denial, "Not my son or daughters." They don't know what to look for; they don't know the early warning signs, and, of course, a part of the illness in these youngsters is the con. They are very good at pulling the wool over their parents' eyes. That is a part of the illness.

When parents first get the early warning signs, there is a tendency to deny again, to minimize. When they finally do confront a youngster, the youngster will admit it and say, "But, Mom, I only do it on weekends. I got it under control. I can quit anytime I want," and which of us, as parents, don't want to believe them? We want to believe that that is so. So there is tendency to let it go.

And, of course, the disease progresses. The youngsters are finally confronted; there is a stage of bargaining; "If you make me go to the doctor; if you make me go to the hospital, I will run away."

Parents are then intimidated; they don't know where to go for help.

Another part of the problem is, of course, that good treatment centers for the treatment of this condition are few and far between. We are playing catch-up ball, talking about the 2-minute drill, when it comes to the diagnosis and treatment of teenage drug abuse. What can we do about it? I list a number of things in my written remarks; I just want to be very brief at this time.

First of all, again, a nonpsychiatric solution, I think that drug growers and manufacturers have to be struck at the source. I also think that there should be stronger penalties for drug dealing. We heard earlier remarks about that today.

Parent education is a must. You know, you can take classes on everything from pasta making to how to be your own best friend, but courses on how to be a mother or father are harder to come by. I think we have got to make them more available.

Parents have to get educated. They have to get in charge, and they have to get involved. You have been asking several of the witnesses, Mrs. Boggs, what can the Federal Government do. The Federal Government, through its own insurance plan for its own employees, Federal employees in the military, the Champus sets the tone. It is a bellwether for benefits provided to employees and it is of interest that within the last couple of years, benefits for the treatment of alcoholism and chemical dependency have been eliminated in the Federal program.

Also, benefits for the treatment of psychiatric illness have been selectively capped at 60 days. I treat some of these youngsters. I know that many of them—not all—many of them do require more than 60 days of hospitalization to begin the process of recovery.

Capping a benefit like this at 60 days is analogous to giving a surgeon 45 minutes of benefits to do an appendectomy and when the 45 minutes are up, the door opens and someone says, "I'm sorry, Doctor, your time's up."

I have listed things that we can do. I made remarks about the schools, some strong remarks and some criticism of my own profession, by the way, for not being as educated as we should be and too often, I think, placing some blame where it doesn't belong, and that is on the parents. Parents are part of the problem, but we share the problem together. One thing is certain, that if we are not all part of the solution, we are not going to get this problem solved. It is an epidemic problem in our society; it is related—it weaves its way through the testimony of virtually everyone who has gone before me today.

I have heard it; I have listened to it and I have learned myself here, and I am very pleased in a sense that I had the opportunity of being last. I have had an opportunity to make notes and learn from the many individuals who have gone before me. I am honored, Mrs. Boggs, that I would be invited to appear before you this afternoon.

[Prepared statement of Dr. Joseph R. Novello follows:]

PREPARED STATEMENT OF JOSEPH R. NOVELLO, M.D., DIRECTOR, THE GATEWAY, A PROGRAM FOR THE DIAGNOSIS AND TREATMENT OF ADOLESCENT CHEMICAL DEPENDENCY

Madame Chairman, Distinguished Members of Congress, Ladies and Gentlemen:

I am Dr. Joseph Novello. I am a physician specializing in child psychiatry. I am Director of Child and Adolescent Services at the Psychiatric Institute of Washington, D.C. and Clinical Associate Professor of Pediatrics and Psychiatry at the Georgetown University School of Medicine.

I appear before you today, however, because of my special interest in the subject of teenage drug abuse and in my role as Director of The Gateway, a comprehensive treatment program for chemically-dependent adolescents between the ages of 13 and 18.

Teenage Drug Abuse. It's not a pretty picture. When you add up the numbers you come to the chilling conclusion that drugs and alcohol, in tandem, are probably the leading cause of death among American teenagers. For example, accidental death is the leading cause of mortality among adolescents but we know that 16,000 youngsters, in a recent year, died in alcohol-related traffic fatalities. Suicide ranks as the second-leading cause of death, yet it's estimated that 50 percent of the 5,000 teenage suicides last year could be laid to booze and pills. No, it's not a pretty picture. It's a deadly picture.

And what about the tens of thousands of youngsters who cheat death but whose chemical dependency cheats them of their adolescence . . . of their growth and development as happy, productive individuals? I'm talking about school drop-outs, runaways, the physically-ravaged and the psychologically destroyed. I'm talking about burned-out 25-year olds, still arrested in their adolescence, because of the effects of things like marijuana, PCP, LSD, and the rest of the lethal drug abuse alphabet soup. These youngsters die too. They die emotionally . . . slowly . . . unless help arrives.

THE DRUGS OF ABUSE

I'd like to give you a brief overview of the drug abuse landscape. But first I should warn that the scene is ever-shifting. Just when you think you've got a handle on it, the landscape blurs. But here's my best estimate of today's problem, based on recent surveys and my ongoing daily work with teenagers themselves.

Alcohol.—Alcohol is clearly the single most abused substance by teenagers. Alcohol, not marijuana or something as exotic as mescaline, is the Number One drug problem of today's teens. A New York Times survey concluded that 3.6 percent of New York City teenagers and 5.2 percent of suburban youth used it on a daily basis. A similar study in the nation's Capitol revealed a daily use of 11.4 percent and a weekly use of 22.9 percent. Conservative estimates are that almost 8 percent of teenagers, on a national basis, have a serious drinking problem. That's not a small number. It translates into 1.3 million American boys and girls. Our children—yours and mine. No family enjoys absolute immunity.

Marijuana.—There's good news and bad news where majijuana is concerned. The good news is that heavy use of marijuana has declined somewhat in the past couple of years. In 1979, 11 percent of high school seniors reported using marijuana on a daily basis; in 1981 this figure had dropped to 9 percent. The bad news is that marijuana continues to be readily available to teenagers . . and use it they do. My best current estimate is that 7-8 percent of high school seniors still smoke it on a daily basis. Not much reading, writing, and arithmetic getting absorbed by their confused, disoriented minds.

Perhaps the most frightening thing about marijuana is that it poses a "trickle down" phenomenon. Younger and younger children are being introduced to pot—usually by older "friends" or even by older brothers and sisters. In our own program, The Gateway, it is not unusual to encounter youngsters who "smoked their first joint" at age 10 or 11.

Marijuana is also a "drug of entry" into the deadly world of chemical dependency. Most teenagers who move from experimentation down the path through the next 3 stages of drug abuse (2. Actively seeking a high, 3. Preoccupation with getting high, and 4. Reliance on drugs simply to feel "normal.") ultimately switch to other drugs in a desparate flight to feel good . . . to set their minds right . . . to grab the ultimate buzz.

PCP.—Phencyclidine was given a trial in the 1950's as an anesthetic agent. The side effects were so severe that it was quickly discarded for use in humans. Today it finds use in only two categories: 1. for animals in veterinary medicine and, 2. as a recreational drug of teenagers and young adults.

PCP, otherwise known as angel dust, or killer weed, is dangerous. It creates a form of psychosis, a temporary loss of reality. It also causes agitation, aggression, and violence. PCP is a hallucinogen. It's easy to manufacture in home laboratories. Its physical properties are often confused with other drugs. Therefore, many young-

sters ingest it accidentally, thinking they're getting cocaine or un-treated marijuana.

PCP use is on the upswing. In Washington, D.C. 4.9 percent of high school students report using it on a weekly basis.

Cocaine.—Cocaine, once the drug of the jet set, is growing in popularity among the prep set as well. In fact, only its high cost seems a barrier to epidemic use among teenagers. Those who do achieve regular access do it, usually, through one of two routes: 1. boys who go into drug dealing in order to afford it or, 2. girls who deal "sex for snow." Hence, cocaine traps teenagers into the shadowy world of illegal hustling and illicit sex—just as it does adults.

Amphetamines.—Amphetamine is now a controlled substance. Its use as an appetite suppressant in the medical treatment of obesity has been discredited. In fact its medical use is now limited to narcoplesy (a rare condition), hyperactivity in children (although other drugs are available), and (rarely) in the treatment of depression.

Yet, amphetamines, also called "uppers," are used on a weekly basis by about 2.5 percent of high school students. Many of these youngsters, by the way, are depressed. Their choice of drug is not accidental. They select it because it picks them up and makes them feel good—momentarily. Amphetamines cause drug dependence: higher and higher doses are needed to achieve the same high. Toxicity can cause a paranoid psychosis. Withdrawal causes a "crash" and a depression worse than the original.

Other hallucinogens.—LSD, mescaline, psilocybin, and company are still with us. They, unfortunately, did not go the way of the Flower Children. And hallucinogens are making a comeback among our youth. They alter perception so that the user will report "hearing colors" or "seeing sounds."

Youngsters have a name for chronic LSD-users. They call them "space cadets," "ozone heads," or "fried brains." These tags are accurate. Heavy use of hallucinogens appears to do permanent damage to the brain—including "flashbacks."

About 1.5 percent of teenagers report regular weekly use of hallucinogens.

Barbiturates, sedatives.—Phenobarbital, Nembutal, Qualudes are sedative-hypnotic drugs. They have a legitimate medical use in sedation and as sleep-inducing agents but they are readily abused. They're especially dangerous because of their synergistic effect with alcohol i.e. one drink plus one pill can equal the effects of three or more of either. Overdose and "accidental" suicide with this deadly combination is not uncommon.

My best estimate is that about 1 percent of teenagers use these substances daily.

Inhalants.—They sound harmless enough: glue, paint thinner, nitrous oxide, lighter fluid. But are they? No. In fact, the inhalants, used mostly by young children aged 6 to 14, are the most immediately dangerous of all substances of abuse. Sniffing these fluids in high concentration can cause brain damage, liver damage, kidney damage—and even death.

Although 1 in 9 teenagers has experimented with one of these substances—regular use is, fortunately, rare.

Tranquilizers.—Minor tranquilizers such as Valium and Librium and major tranquilizers such as Thorazine—are "our" drugs, the drugs of the adult, or Valium, generation. Maybe this is why teenagers are not much attracted to them. Another reason is that they don't give an immediate, discernable rush or high, or perceptual distortion like the previous drugs I've mentioned.

The main danger of these drugs is probably that adults, including parents, who turn too quickly to a pill to solve a problem are sending a powerful message to the children who watch in the wings—"better living through chemistry."

Heroin.—Heroin is a drug of young adults. Less than 1 percent of adolescents use it on a regular basis—although I am alarmed that street dealers increasingly use small children (8-12 years) to "hold" for them—and that "smack," as it is sometimes called, seems to be more accessible now than ever to teenagers, especially in large cities.

There you have it. A quick trip through the teenage drug world landscape—1983. As I said, it's not a pretty picture. But we can learn from it. We can learn and we can do something about it.

We can start by examining the causes of adolescent chemical dependency. As a psychiatrist, a physician, I'm interested in what causes an illness—and chemical dependency is an illness. As legislators the members of this Committee also want to examine causes . . . afterall, just as in medicine you must diagnose problems before you can treat them.

CAUSES

There are many causes of teenage drug abuse.

Availability.—You have to start with the obvious. Alcohol and illicit drugs are amazingly available to youngsters throughout our nation. No school, urban—suburban—or rural, is immune. No city, town, or village is safe.

Adult modeling.—It's been said that we live in a Valium Society (for some make that Jack Daniels). Teenagers do as we do—not as we say. Teenage alcoholism and drug abuse tends to be a family affair. For example, a child of an alcoholic is four times more vulnerable to alcoholism himself than a child of non-alcoholic parents. Genetics is certainly a factor in these cases—but the environmental influences are important too.

Chemical dependency as an illness.—One of the least understood factors in the prevention and treatment of teenage drug abuse is that Chemical Dependency itself is a disease. Many youngsters are genetically susceptible or developmentally vulnerable to this illness. Once they are exposed to drugs and alcohol the disease flourishes; they are helpless against their chemical—unless they receive proper treatment.

It is crucial that we understand this concept. I must admit that even as a physician I did not fully appreciate it until after I had worked with three youngsters for quite a long time. Traditional medicine and psychiatry takes the view that "you drink because you have a problem." Therefore, treatment is aimed at the underlying "problem" and the theory is that the symptom (drinking or drugging) will disappear as the "problem" is resolved. Well, I can tell you that it just doesn't work that way. I've seen too many youngsters, cured of their psychiatric illness in a hospital setting, go right back to drug abuse after release from the hospital. The result is a double tragedy: the youngster faces not only the perils of continued drug abuse but, sooner or later, the psychiatric illness (depression etc.) also returns—usually with a vengence.

If you view Chemical Dependency itself as an illness there is only one realistic philosophy: "you have a problem because you drink." Treatment, therefore is aimed not at the underlying "problem" but at the chemical dependency through drug education, confrontation, the principles of A.A. and a host of "non-traditional" methods ("non-traditional" to most physicians anyway). The concept is, of course, that "if you will stop drinking or drugging, you won't have a problem at home, at school, with friends, with the law etc." This approach is effective with many teenagers. It should be pointed out, however, that the adolescent drug abuser, by virtue of his adolescence, has suffered psychological scars and developmental delays in ways that, say, an adult alcoholic has not. Treatment, therefore, should be in the hands of specialists in adolescent work who, while focusing on the chemical dependency, can attend to these unique issues as well.

Psychiatric illness.—In addition to youngsters whose primary problem is the illness of Chemical Dependency, there are many teenage drug-abusers who are psychiatrically ill and who turn to alcohol and drugs secondarily. They suffer from depression, impulse disorders, and schizophrenia. Their drug abuse is actually a secondary effort to medicate themselves: speed for depression, downers for agitation and agression, hallucinogens for the raves of psychosis. Their rehabilitation must start with a precise medical diagnosis and be followed by a two-tracked treatment program aimed at both the primary and the secondary illnesses.

Family breakdown.—Busy parents of the me-generation may not have enough time to supervise their children even when the family unit is intact. Broken families pressured by conflicts and special needs are especially vulnerable. Financial pressures have led to the phenomenon of 60 percent of mothers with children under the age of 18, employed outside the home. Jobless parents, especially minorities, may project a sense of hopelessness and despair . . . a breeding ground for drug abuse by their own children.

Mobility.—We are a mobile society. The average American family moves over 10 times in its lifetime. One result is that neighborhood support has all but vanished from most of our lives. When we were kids you didn't get away with so much—there was always some adult around who would call your parents if you did something wrong.

Peer pressure.—You can always count on a young druggie to want to corrupt nonusers. Why? It makes him more powerful and "levels" everyone to his values. As a result, there is tremendous pressure on almost all teenagers to try drugs—"just this once."

Secular trend.—Youngsters enter puberty at an ever earlier age. The onset of puberty, for example, occurs about 3 months earlier, on the average, every decade. We

have the phenomenon, for example, of 12-year old girls "going on 22." It's a different problem for teenagers-and for parents too.

Permissive parenting.—As a nation we are still paying the price of permissiveness—that non-prescription for successful parenting that urges mothers and fathers: "don't repress your child's drives, let him find his own way." Too many parents find it hard to say "no" to their children. They're intimidated! One caller, the mother of a 13-year old daughter, to my Washington, D.C. call-in radio program, asked if she "had a right" to ask her daughter not to smoke pot in the house." A right?" I asked incredulously. "Well, I mean doctor, it is her life isn't it!" was the response.

Lack of education.—The word is starting to get out but too many parents are still naive and under-educated when it comes to teenage drug abuse—even when it stares them in the face.

There's a tendency to deny that it could happen. "Not my child," is a familiar reaction. And why not? Which of us wants to be confronted with such a monstrous reality. Yet, even when the problem can no longer be denied there's a tendency to minimize ("thank God it's only alcohol—not hard drugs") and to give into a youngster's desperate bargaining ("I'll be good—just don't send me to a hospital. I can quit any time I want.") Parents also allow themselves to be intimidated at the stage of discovery: "If you make me get treatment, I'll run away."

Finally, parents, perhaps out of the mistaken belief that they are the cause of the problem, avoid going for help . . . . preferring instead to "solve the problem at home." Sadly, home remedies rarely work for this serious illness.

Media.—Media glorification of drinking, drugging, and the "fast life" may simply mirror society (as apologists claim) but it's too often part of the problem. Programming, news, and advertising must all be held accountable.

WHAT CAN WE DO ABOUT IT

First, I want to stress that there are many causes for the epidemic of teenager drug abuse that we currently face in the United States. No one single group or institution is at "fault": not the federal government, not parents, not the schools, not the media, not even psychiatrists—and surely not the teenagers themselves.

Yet, if none of us stands alone as the problem—we must stand together as the solution.

I salute the efforts of this Committee's search for the answers. I know that I will learn a great deal in listening to the testimony of others here today. Perhaps, by working together, we can arrive at some answers.

For my part, I would offer the following suggestions:

1. Drug trafficking.—Law enforcement agencies on all levels should be given the resources to do their job well. Striking suppliers at the source is still the most direct route at eliminating illegal drugs from the streets of cities and the playgrounds of our schools.

2. Drug dealing.—Stiffer penalties for drug dealers, adult and adolescent, is a must.

3. Parent education.—You can take a course on almost anything these days: pasta-making, racquetball, aerobic dancing, even How to Be Your Own Best Friend. But what about "How to Parent?" Those courses are tougher to find.

Being a parent is the most important job any person will have. It has to be given a higher priority in our society.

For adults I suggest a parenting course before the first baby arrives. Shop carefully. Be sure the philosophy of the teacher is acceptable to you.

My own formula for successful parenting (described in my book, Bringing Up Kids American Style) is deceptively simple: Values Clarification, Communication, and Discipline.

But books are not enough. Parents should be encouraged to get back in charge of their families again. Too often, in my work, the real power rests in the shaking hands of a scared, 14-year-old druggie.

Parents should also get together with other mothers and fathers. "Can you name your child's three best friends?" I often ask. If you can't, you've got a problem. If you can, you've got the beginnings of a Parents Group.

Finally—parents should be encouraged to: 1. Get Informed, 2. Get Together, 3. Get Involved.

4. Recognition of chemical dependency as an illness.—Teenage alcoholics and chemically-dependents have an illness requiring treatment. As long as we persist in the myth that they are simply "bad kids" or somehow "morally deficient" we will not be able to help them. You can't talk them out of it. It isn't the parents' fault. Going for treatment must not be stigmatized. If anything treatment, not the drug

use, should be glamorized. The teenager who licks drug dependency is a hero—like Betty Ford, like Richard Pryor, the straight-again teenager is a celebrity in my book.

5. Federal Government.—The Federal Government through the medical insurance benefits it provides its employees in the Federal Employees Plan (FEP) and CHAMPUS for its military beneficiaries and their families sets the tone for insurance carriers throughout the country. It is a bell-weather. Sadly, benefits for alcoholism and chemical dependency have been eliminated . . . . perhaps because these employees and their family members are not seen as ill but rather lacking in moral fortitude.

Sad too, that benefits for psychiatric illness have been selectively capped at 60 days for hospitalization. I can tell you that most teenagers who suffer combined psychiatric illness and chemical dependency require more than 60 days of inpatient treatment—but 60 days is all they can get. It's analogous to be giving a 45-minute benefit for an appendectomy: "Sorry doctor, we'll have to take your patient off the operating table now, your time is up."

6. Treatment programs.—But even if adequate insurance benefits come available, where is a family to go for help? This is a question I'm asked frequently in my professional work, in my media work in WJLA-TV in Washington, and through letters to my weekly column in Woman's World Magazine. Where to get help? What to look for in a program? I asked myself these questions before designing my own program, The Gateway. I visited a number of facilities across the country and interviewed leaders in the field. Based on this research I have outlined 12 basic criteria:

1. Illness.—Chemical dependency should be viewed as an illness. Teenage drug users are not "bad" or morally deficient. They have an illness requiring treatment.

2. Diagnosis.—Many programs are long on treatment, short on diagnosis. Not all drug abusers are alike. Medical and psychiatric diagnosis is an important first step.

3. Residential.—The first phase of treatment (approximately 2-4 months) must usually begin in a hospital or residential facility where de-toxification can occur—and the youngster can be kept safely from "his chemical."

4. Family.—Treatment must involve the family as partners.

5. Abstinence.—The goal of treatment must be sobriety, complete abstinence.

6. Psychiatric, medical.—The program must be able to treat concomitant psychiatric and medical illness.

7. No cults.—Some programs resemble cults. Avoid them. You may be trading one problem for another one.

8. Recovering staff.—In addition to physicians and nurses, good programs have some staff members who are "recovering" drug users. They lend credibility and role-modeling for youngsters and provide drug education.

9. A.A.—The philosophy of A.A. and its 12 Steps should be at the core of the program.

10. School.—The program should offer ongoing academic classes, preferably for credit, while the youngster is in treatment.

11. Aftercare.—Successful programs offer a year or more of structured aftercare. This post-hospital or post-residential phase is the key to ultimate success.

12. Lifestyle.—The program must promote a new lifestyle, free not only of drugs but free of the "wrong friends." It must replace old values with a new, positive outlook on life.

CONCLUSION

A positive outlook on life. Those are hopeful words and good words on which to end my remarks. I hope my comments have been helpful and positive. My own outlook is brightened by the work of this Committee and the hope that it offers to the Children, Youth, and Families of our nation. I'm honored that you invited me to address you today. Thank you.

Mrs. BOGGS. We are certainly honored to have you, Doctor, and thank you very much.

I notice, of course, in your testimony, you have referred to the secular trends and to the effect of the media and so on as well. We are very grateful for your testimony, which we have had the opportunity to read and we will reread with even more interest now.

Mr. Fish, would you like to ask your questions?

Mr. FISH. I want to thank all the witnesses.

Mr. Covino, I was going to ask you to write a letter but apparently we have a reprieve here of a few more minutes in this room. Several things about your program in your library I find interesting. This budget you speak of of $100,000; now, is that budget for the library or just for Levels?

Mr. COVINO. That is the budget just for personnel programs in Levels. The budget for the library is almost $3 million.

Mr. FISH. How do you raise that kind of money?

Mr. COVINO. Our budget is voted upon by the community every year. It goes to the community; the community must——

Mr. FISH. Just like a school board, you mean?

Mr. COVINO. Just like the school budget. We have never lost one. Last year, 4-to-1 margin.

Mr. FISH. Is this typical in New York?

Mr. COVINO. That record, no.

Mr. FISH. No, I mean to have budgets voted on?

Mr. COVINO. Quite a few libraries——

Mr. FISH. Really?

Mr. COVINO [continuing]. Though many do not, depending on the form of library.

Mr. FISH. You are talking here about 3,500 square feet, something like four or five times the size of this room. Do you know of any scaled-down operation? I am trying to see if you could be a model for smaller communities, smaller libraries, but cities with great needs?

Mr. COVINO. Yes. We really were fortunate in terms of having the resources that we do and having the kind of support that we do. But really where a lot of it is in terms of the people you have who work with the kids; how they deal with them and the risks you are willing to take with them.

I think that is the critical thing. Dollars, obviously, are very important, but you necessarily start on the smaller scale and it is possible on the smaller scale. My feelings are that you start on a smaller scale and you show adults in the community that it is possible and it does work. That is where you get support, and you have to prove it to your parents and to the kids.

Mr. FISH. Do you have a large minority population?

Mr. COVINO. Fairly large in terms of black. A lot of Asiatics——

Mr. FISH. Do you have a black history library in part of your library?

Mr. COVINO. When we started the free bus service, I did it—I started it almost because I wanted to hit the black areas. Every Monday and Wednesday night, we would get between 50 and 60 black kids on that bus. Monday and Wednesday nights was their library night. It posed a lot of problems in terms of the people saw it as a white institution and the kids had to learn how to deal with a white institution, but it has all worked out and——

Mr. FISH. My question is whether or not you had a part of the regular library that dealt with the subject of black history and whether that was popular with some of the young people.

Mr. COVINO. We have had for the past 10 years a black arts show. We have black poets. We have a large black history book collection. We have many programs which tie in with black history but we don't really emphasize that as such because I think where

it is at is what you do every day. Hire black employees, put black kids in positions where they can do something for themselves and prove things to themselves. So what we really emphasize is doing what we can do for them on a daily basis.

Mr. FISH. Finally, about the people you get because you have these art shows and theatrical performances you require a great many different disciplines. Are you having success in getting people to volunteer to come in at some of these hours to help or do you have to pay everybody?

Mr. COVINO. We have paid staff, two full-timers, roughly five to six part-timers. The part-timers we usually try to get are people who have done professional work in the various arts. A lot of the kids are skilled—there is a great deal of peer teaching and in terms of theater, it is all theirs. Adults don't have anything to do with it. They have got to do it all. We pay for the book; they select. It is a learning situation and we literally keep adults out of it.

Mr. FISH. Thank you very much.

Thank you, Madam Chairman.

Mrs. BOGGS. Ms. Johnson.

Mrs. JOHNSON. Thank you. I would just like to take this opportunity to express my regret to those of you in the room whose testimony I wasn't able to be here for, but we do—most of us—read it if we miss it. I do very, very much appreciate your all coming here today and sharing with us the work that you do in your lives, which is really so terribly important and will help us to find those ways that we feel are so badly needed in today's world.

I do appreciate your testimony. I appreciate the quality of the effort that you have put out in your lives and the contribution that you are making and I particularly appreciate the young people for coming today and sitting through a long hearing and sharing with us your experiences and thoughts as well.

Thank you very much.

Mrs. BOGGS. Mr. Covino, I was really sorry to have to go over to vote when you were testifying because I read with such personal interest the great work that you are doing at Levels. I was a librarian teacher when I was only 19 years old in a rural community where the school had fortunately been left a beautiful library by a private citizen, even though it was a public school. I was able to extend all the uses of the library to parents and to other people in the community. They all became interested and the kids became interested and it became a cultural center.

I know what great work can be done in this regard and the fact that you have extended it so fully and have involved young people so remarkably is something that I compliment with all my heart. I was just wondering, Danny, have you ever done "Once Upon a Mattress"?

Master SONENBERG. Not me. Adam over there has.

Mrs. BOGGS. Have you?

Master SONENBERG. Adam has—no, I never did the show. I have seen the show, if that helps.

Mrs. BOGGS. Well, just a couple of weeks ago, I went to see my granddaughter, Rebecca, as the Princess, so I know what fun you can have in afterschool programs of this sort. I think that so often the young people who come from more affluent families are really

disregarded and that is one of the great services that your program performs.

Mr. Stewart, I was so pleased with all of your comments. I was especially interested that, just as Dr. Novello said, that you have to have some sort of discipline and you have to make people care and that you don't, you know—you won't really be like these alleged negative places such as school if you do require some discipline.

I wondered if you have involved—I know that you have involved Human Services agencies in the center 54 program to provide good followup health care, mental health service and so on. Can you tell us more about how that works and how you develop those links?

Mr. STEWART. Sure; in upper Westside, we have a coalition of agencies—we call ourselves the upper westside task force for youth—and the four participating agencies in my program are also members of that coalition. What we try to do, if we can't service—if there is—let's say someone has an eye problem—he is having difficulty seeing, we don't have a clinic right on the school property, but one of the participating agencies, Ryan Teen Health Clinic, has people who can do eye exams. So we will refer them out and also send either a team council member or one of my staff with that person so they can do an immediate followup.

Someone who is asking for advice about pregnancy, if you followup 2 months after the fact, you are not—you are cosmetic; you are not a real service.

Mrs. BOGGS. Right.

Mr. STEWART. Again, what we try to do is have a team council member as a liaison person so they won't be intimidated by an adult is maybe removed from that situation, or we have a, let's say, Kung Fu class, and the teacher in the Kung Fu class is also my health educator. He gets close to the youths involved. They are not hesitant to ask for help if they need it. Again, we just try to network people right at the center.

Mrs. BOGGS. You are one of those team counselors, aren't you, dear? Victor?

Mr. MARTE. Yes.

Mrs. BOGGS. And do you find that work very rewarding?

Mr. MARTE. Yes, because basically I am the president of the team council and we get the suggestions from the participants of the center and we try to put them in functions, like try to set up trips. Instead of just going in and playing basketball or other sports, we plan our trips and maybe to basketball games, sort of, to expand the center to the community and pass on the ideas to younger people.

Mrs. BOGGS. Ms. Shore, I was very, very pleased that you made the differentiation between runaways and homeless children and young people. Have you found a great increase in the homeless children in the last couple of years due to severe economic conditions?

Ms. SHORE. Yes, I think that we have seen that increase. As I mentioned in the testimony. Also, there are more young people coming from long distances than we had. There was a period in the early 1970's where there were a lot of young people traveling around the country but this had really leveled off. That has now increased again.

The number of young people who are homeless in our city has also increased. We have seen probably an increase of 10 percent, between 20 and 30 percent of our young people who need a great deal more in the way of service, especially long-term service, as compared to the runaway youth who can return home.

Mrs. BOGGS. Are you finding that a lot of families simply don't have homes at all and each kid has to just go out and scrounge for herself or himself?

Ms. SHORE. Yes; we have seen many teenagers of families who themselves have become homeless. There is such a large population of homeless people in the District, but there has been little focus on what this means to the young people who are often forced out on the streets.

We have many young people who, because they are the teenager, were told, "You can now fend for yourself at 15 or 16 or 17. The rest of us have to figure out how to take care of each other." In these cases in addition to looking for shelter, there is also often some very damaged relationships in the family that we work with as well.

Mrs. BOGGS. It is a shame that we have to be going from the room, but at least we have to go to vote anyway so it relieves me a little bit from not being able to spend more time with you.

Dr. Novello, the program that you direct, the gateway program, I assume, incorporates all the features you have recommended for an all-drug treatment program. Do you think that this can be adapted to other programs, that they can adopt the kind of features that you have incorporated into Gateway?

Dr. NOVELLO. I think so. When we designed this program, Mrs. Boggs, I toured the country and visited some of the centers that are considered among the leading centers and interviewed leaders in the field and tried to combine the best of all possible worlds. I think probably a good step for those of us in this particular part of the work would be to get together, convene a meeting, and share information. It is hard for individuals to do that kind of moving around, and to design a model kind of program that could be adapted to local needs.

Mrs. BOGGS. Do you collect information about recidivism and other indicators?

Dr. NOVELLO. Yes, we do. Our own program, however, is too new for me to give you meaningful data. Many programs that have been operating for several years are reporting success rates in the area of 70 to 80 percent, success meaning abstinence, complete abstinence from drug use and resolution of any psychological problems. That is a good success rate, by the way, something really to show.

Mrs. BOGGS. Yes, that is. We started the day on communications and I was very pleased to know that you communicate so specifically, both in your WJLA program and your weekly column, which is certainly an extension of your own workweek, but it does communicate most beautifully.

Dr. NOVELLO. Thank you very much.

Mrs. BOGGS. One of the questions that Mr. Miller would have liked to have asked, had he been here, Mr. Stewart, was, is there some way that the private sector can get involved to help you keep

your program during the summer months? Could IBM or another computer company donate computer equipment to your program?

Mr. STEWART. Yes. We do try to touch base with many area private industries. We have had people from the Private Industry Council, PIC, offer jobs so we could do referrals outside. Again, we are trying to start a computer program and Apple has contributed a couple of computers toward that. We are always receptive to outside offers.

Mrs. BOGGS. I would assume that in your remedial program, the computer type, learning-to-read programs and so on would be very useful.

Mr. STEWART. Again, with this video era and kids plugging and tuning into all these games you see on TV, you cannot get game—you cannot get a job with these games, but they can make the transition on the keyboard to a real computer very easily if we, again, do it while they are younger, rather than wait.

Mrs. BOGGS. Mr. Miller had a followup question for you, Danny. He said that it sounds like Levels has been a very helpful and exciting experience for you. It must be a comfort to your mother to know there is a program like Levels for you to go to after school now that she is planning to return to work.

Would you agree?

Master SONENBERG. Yes. It is a great comfort for her because when my sister first started going to Levels, she wasn't—I mean, for the first few months, I mean, I had all these wild dreams about what this place was because I was much younger then and my mother—generally, I am sure, with places like this everywhere, I mean, rumors have to be spread that there are drugs going on there, things like that, which isn't the case, but then as soon as my mother started to see what was happening, she just felt very comfortable, and now, as I said, there is—if I have nothing to do and have finished all my homework from school, I can just go down to Levels if my mother is not home and things like that.

Mrs. BOGGS. We are so glad it is such a good experience for you and I am going to ask Mr. Wolf to take over while I go to vote. Before I leave to close the hearings, I want to thank all of you, those of you who have testified, those of you who helped to prepare the testimony, and those of you who have accompanied them and those of you who have been here to listen.

Please go out and use the knowledge that you have acquired and share it with others as Ms. DiFiglia here today shared her painfully arrived at knowledge with all of us. Thank you so much.

Mr. Wolf.

Mr. WOLF. I have to go vote, too. I want to apologize to the panel for not being here. I had an obligation with a group of constituents. I got back as quickly as I could but regret that I missed your presentations. I will however, read the testimonies and I want to thank you and ask for your acceptance of my apology. Thanks again.

[Whereupon, at 2:30 p.m., the subcommittee was adjourned, to reconvene subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

HARVARD UNIVERSITY,
SCHOOL OF PUBLIC HEALTH,
Boston, Mass., October 31, 1983.

Hon. MRS. LINDY BOGGS,
Committee on Children, Youth, and Families, House Annex 2, Washington, D.C.

DEAR MRS. BOGGS: I would like to thank you for inviting me to testify before your task force, and I apologize for not being able to stay up to the end of the third panel's testimony. It was a great honor for me to appear before your committee. I hope that my testimony served to underscore the immense public health problem presented by suicidal, self destructive adolescents. In listening to other witnesses, it occurred to me that there were three major themes we all mentioned.

The first is our dearth of knowledge on the causes of self destructive behavior among today's youth. To address this, we need more research. The federal government might wish to signal its commitment in this area by specifically allocating funds to study a range of potential risk factors. Secondly, the witnesses cast doubt on whether the traditional approaches to adolescent problems are really efficacious. Those teenagers who are willing to receive counseling or psychiatric therapy usually are able to profit from it, but for many, these traditional therapies carry an unwelcome stigma and are thus rejected. Thirdly, it was clear from all of the testimonies that the use of adolescents themselves as peer counselors has been largely overlooked. Teenagers are perhaps in the best position to identify youngsters in trouble and to offer a helping hand in a non threatening way. Adolescents are an extremely valuable and untapped resource if they can be given the appropriate training and back-up. Here again, the federal government may wish to take an initiative by supporting the development of model curricula which could be incorporated into health education programs starting at an early level.

Lastly, I believe the federal government should re-examine its priorities. Our huge military expenditures are draining our ability to assist the weak and vulnerable members of our society. If we cannot defend the most defenseless we are misguided in thinking we are all protected.

Sincerely,

EVA DEYKIN, DR. P.H.,
Assistant Professor.

LOUISIANA ASSOCIATION OF CHILD CARE AGENCIES,
Baton Rouge, La., November 1, 1983.

Hon. LINDY BOGGS,
Chairperson of Task Force-Crisis Intervention,
Select Committee on Children, Youth, and Families,
Rayburn House Office Building, Washington, D.C.

DEAR REPRESENTATIVE BOGGS: Please allow me to express on behalf of the Louisiana Association of Child Care Agencies our sincere appreciation for the opportunity your committee has provided for input from our organization regarding "Teenagers in Crisis". We would like to request that this letter be made part of the hearing record of October 27th for the Select Committee on Children, Youth and Families.

The Louisiana Association of Child Care Agencies represents forty private nonprofit provider agencies in Louisiana providing services for some 1,422 youth. Our agencies consist of emergency shelters, crisis centers, group homes, and other residential treatment programs for abused, neglected, disabled, and court referred youth.

We believe that services for homeless youth and related programs should be a national priority. In Louisiana there are literally thousands of young people in placement including all programs public and private. In spite of this significant and growing number of troubled youth, funds have been reduced for placement and treatment programs. The total of state and federal resources available for residential treatment, follow-up, and counseling are less today than they were five years ago. Because of this lack of funding, kids who need a structured, closely-supervised program of treatment are not getting it. Turning to families and private resources is not the answer. The prolonged recession has stretched private resources to the limit and the resultant stresses actually contribute to rather than deter the breakdown of support systems within the family and community.

The crisis issue for the kids involved comes from (1) the child having to leave home due to environmental conditions usually beyond their control, and (2) the resultant feelings of worthlessness as they assume the guilt and blame for the breakup of the family unit. Because of these critical needs, new programs must be devel-

oped in shelter care and crisis intervention services. In addition to these short-term services, after care counseling programs need to be developed for kids in transition from residential treatment to foster care or back home to their natural parents; and finally, preventative programs for high risk youth must be initiated that include early recognition, intervention, counseling, and referral to appropriate treatment programs.

Our member agencies are already broadening their services to include many of the necessary components of prevention, treatment, and follow-up described in this letter. But, expanding services with diminishing resources is not only impractical but also spreads program delivery services dangerously thin. In order to be truly effective in each phase of treatment, we must have renewed support and commitment on the part of the Congress and governmental agencies to provide the resources so desperately needed by our troubled and homeless youth.

Our association pledges its continued support of your efforts through the Special Task Force on Crisis Intervention. If we can provide additional information or service, please let us know.

Thank you, and

Sincere best wishes,

JOSEPH "BUTCH" PASSMAN,
ELIOT S. KNOWLES, Jr.,
President, LACCA.

RAINTREE SERVICES, INC.,
New Orleans, La., November 2, 1983.

Hon. LINDY BOGGS,
Chair, Task Force on Crisis Intervention, Select Committee on Children, Youth, and Families, Rayburn House Office Building, Washington, D.C.

DEAR REPRESENTATIVE BOGGS: On behalf of the Board of Directors, staff and residents of Raintree Services, Inc., I am requesting that this letter be made part of the hearing record of October 27, 1983 regarding "Teenagers in Crisis—Issues and Programs". Raintree Services, a private non-profit corporation, is a group home for emotionally disturbed adolescent girls between the ages of 12 and 18. We appreciate the opportunity to share our views and concerns with you and the Task Force on Crisis Intervention.

Since 1974 Raintree Services has provided residential care and counseling to 94 adolescent girls who have been removed from their homes due to serious family problems, abuse, neglect or behavioral problems. The program's funding is primarily from state and federal sources with additional funds from local community. The purpose of our program is to provide corrective emotional experiences to these young women so that they can have satisfying and productive lives. 36 percent of our clients return home or move to foster homes after placement at Raintree. The remaining 64 percent of our clients cannot return home due to problems within their families (i.e. severe abuse or neglect, rejection by the family, no available family, illness; drug or alcohol abuse). Our great concern is for these clients who have no family support system. Their futures are dependent on their ability to move from our program to total independence in a relatively short period of time. Their ability to become self-sufficient is severely hampered by their poor self-esteem, lack of education and limited financial resources.

Raintree's goal with these clients is to assist them in developing the skills and abilities to be successful productive adults. We feel that these clients are of particular concern when considering teenagers in crisis because their move to independence is so problematic. The struggle for independence is difficult at best for adolescents, and this struggle becomes more difficult when coupled with the emotional, physical and educational deprivation suffered by many of these girls. 75 percent of the clients moving to independence from Raintree have been successful in establishing and supporting themselves within the community. The clients who have not made the transition generally return to the dysfunctional dependent family unit or turn to a life on the street. Often they become dependent on government programs to sustain themselves. These young women want more for themselves than a dependent or degrading life style, but their resources for developing a better life for themselves are limited. Outlined below are some areas in which Raintree is working to better the odds for these girls.

(1) Developing educational resources that allow the client to gain the educational foundation needed to support herself.

(2) Pursuing vocational training programs that give the client marketable skills.

(3) Assisting the client in locating a part-time job while she is still in the Raintree Program so that she can develop the financial resources to establish herself.

(4) Providing life-skills training to the client in the areas of budgeting, shopping, cooking and personal care.

(5) Offering counseling to the client regarding her fear of independence and establishing a supportive relationship with the client so she feels that she has a support base on which to build her own life.

(6) Making available supervised apartment living for the client on a time-limited basis when she moves out of the Raintree House Program.

(7) Providing follow-up services to the client once she has established herself in the community.

Although these services have been useful and effective in assisting young women in "making it on their own", some problem areas exist which hamper our efforts.

(1) The education system in our area does not adequately meet the needs of our clients who are often behind in school and need remedial work.

(2) The vocational training programs in our area are limited and are not always targeted to marketable skills.

(3) State and Federal policies dictate that clients must contribute a portion of their income from working to the cost of their care, thus depleting the financial resources available upon leaving the program.

(4) Employment opportunities to teenagers are very limited and the salaries that are available are not adequate to the needs of a young person trying to live independently.

(5) Funding for follow-up programs is limited, although their cost-efficiency and long term effectiveness are evident from our statistical information.

Faced with these problem areas, clients often become discouraged and surrender to a life-style that is not satisfying or self-reliant.

Raintree Services, which was established in 1926 as the Protestant Home for Babies, has a long history of providing services to meet community needs. Once again we are addressing a difficult and complex need area in working with older adolescents who have been in residential care and need to become self-sufficient citizens in the community. The transition from dependence to independence is a difficult one for these young people and certainly a major crisis in their adolescent years. National attention and concern should be drawn to this growing population of young people who have not received proper care and support from their families, and yet are expected to and desire to make a better life for themselves. They are an important part of this country's future and their ability to support and care for themselves is directly related to this nation's ability to reduce the number of people dependent on the government for their livelihood. We cannot ignore the critical need to support these teenagers to be the best that they can be. Raintree Services and like organizations throughout the country are seeking to assist these young people through the development of effective education, vocational counseling and follow-up programs. We ask that the Task Force join with us in supporting the efforts of these young people and the programs that serve them.

Thank you for the opportunity to comment on these issues as they relate to the Task Force's review of "Teenagers in Crisis". Please feel free to contact me for further information.

Sincerely,

GWEN MARTIN, BCSW/ACSW,
Executive Director.

DIVISION OF ADOLESCENT MEDICINE,
Los Angeles, Calif., November 15, 1983.

Hon. GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Family,
House Office Building, Washington, D.C.

DEAR REPRESENTATIVE MILLER: I have just had the opportunity to review the testimony of Kim Fields, given before the House Select Committee on Children, Youth and Family, and feel that I must give credence from the professional vantage point to statements made in her testimony. Youth indeed are at a disadvantage, not only because they are disenfranchised, but also that the dysocial minority publicised in the popular media serve as poor advocates for the needs of youth. Adolescents and young adults, although struggling for independence, are often dependent upon the family, community and greater social system to provide for their health and medical care. They are the only segment of the population in the U.S. today in which mor-

tality rates are increasing. These mortality rates are the result of problems which have complex etiologies and very little available community resource for intervention. Program cutbacks at state and Federal levels have in many cases denuded communities of already existing meager resources. For instance, despite the fact that suicide is the number 3 killer of adolescents and young adults in the United States, recent county cutbacks have threatened discontinuation of our Crisis Hotline Service which has received up to 12,000 calls annually since its inception in 1968. A High Risk Youth Project focusing on runaways and throwaways and utilizing a unique community intervention model has only limited resources from the Robert Wood Johnson Foundation in New Jersey to provide services to a street population which is only increasing in numbers. Youth without the support of family often receive second class health and medical care in a nation which prides itself in the quality of its health institutions.

Kim's personal experiences only accentuate the need to not only develop an active program of youth helping youth but also a network of resources for young people in a nation as great as the United States. Young people, because of the lack of resources within their own communities reach out to people like Kim and other media personalities who portray equivalents of their dilemma hoping for some guidance and self-esteem.

I commend you and your Committee for addressing such an important issue as children, youth and families. I do hope that the impact of your findings and recommendations will be felt on a concrete level by every young person in America.

Sincerely,

R. G. MACKENZIE, M.D., *Director.*

THE SUICIDE AND CRISIS CENTER,
Dallas, Tex., November 10, 1983.

Mrs. HALE BOGGS,
Task Force on Crisis Intervention, Select Committee on Children, Youth, and Families, House Office Building, Annex 2, Washington, D.C.

DEAR MRS. BOGGS: I would like to submit an additional recommendation to the Task Force on Crisis Intervention. During my testimony at the Public Hearing on October 28, 1983, you asked what action I thought was appropriate for the Committee to take to reduce the suicide rate among adolescents. I responded with the recommendation that more research was (and is) needed to understand the complicated personal dynamics and sociological factors involved in suicidal behavior and to evaluate intervention strategies.

I would further recommend that a national commission be formed with the purpose of coordinating efforts to reduce the youth suicide rate. This commission would be able to pull resources together from all the disciplines that recognize the problem and are currently working as separate entities. If a representative from each field; research, clinical, crisis intervention, academic, medical, etc., had a forum for both short and long term planning, the efforts that are now being made separately would be much more effective. There are precedents for such as national commission, such as the National Commission on Diabetes. The benefits of a suicidology commission would help alleviate one of the nation's major public health problems.

Sincerely,

JUDIE SMITH,
Program Director.

CHALLENGING ADOLESCENT SUICIDE

The Suicide and Crisis Center of Dallas, Texas, an accredited center of the American Association of Suicidology (AAS), joins with individuals and organizations throughout both national and international communities in seeking innovative, timely approaches for addressing a rather startling increase in the phenomenon of adolescent suicide. According to the 1982-83 Statistical abstract of the United States the suicide rate for men ages 15 to 24 is 20.4 per 100,000 and 4.9 suicides per 100,000 people for women ages 15 to 24. In the Dallas metropolitan area suicides among young people have occured frequently enough to assign to the area the second-highest rate in the nation for people ages 15-24. Psychiatrists of the University of Texas Southwestern Medical School in Dallas finds the suicide rate among Dallas-area adolescents to be approximately 2.5 times greater than the national average. Although metropolitan Dallas' suicide rate among adolescents is significantly higher

than the national average, it is by no means a problem unique to one area of the country. Indeed the tragedy of adolescent suicide may be found in communities across the nation, whether large or small, and continues to challenge us all to find ways of helping which will decrease this waste of human life.

Researchers suggest strong relationships exist between youthful suicides and a noteworthy decline in the durability and quality of relationships in general, and families in particular. Additionally, a growing mystique and preoccupation with suicide as an alternative to emotional pain seems to indicate an increasing acceptance among youth to actively seek this "permanent solution" to their difficulties. The increased availability of mood-altering drugs and their use had tended to retard or altogether deter emotional maturity which enhances one's ability to tolerate frustration. Such intolerance for frustration, when combined with increased emphasis upon young people delineating career, educational, and interpersonal goals at ages earlier than their development supports, creates for our youth a pressurized situation from which suicide often seems the only viable escape. Instability within the economic and employment arenas of our nation has often supported multiple moves among families seeking increased stability for their families' finances. Such moves have contributed to a general rootlessness among our youth and an absence of friendships with depth and durability. The significant losses associated with such moves, and the failure to establish new attachments, are frequently reported as contributors to suicide crises. A trend towards increased personal permissiveness, fragmentation of traditional support structures, and a decrease in a commitment to personal self-discipline also seem to preclude many youth from handling their problems in adaptive, effective ways. Adolescence is a time of stress and turmoil which yields youth more vulnerable to the frustrations and disappointments which accompany daily life. Often, therefore, severe disruption in a young person's life is misinterpreted as a "phase' from which emergency is certain, thereby precluding the youth from being seriously considered a suicide risk. Suicidal crises among adolescents frequently go unnoticed or, more tragically, unheeded. In order to better address the problem of adolescent suicide we must remain firm in our resolve to continue research of the factors supporting such actions among our youth, as well as initiate a nationally-recognized emphasis upon prevention of suicide.

The Dallas Suicide and Crisis Center, which has served the metropolitan Dallas area since 1969, has attempted to remain innovative in its program emphasis while also remaining sensitive to the needs for fiscal responsibility. A local Board of Directors solicits and disburses funds from throughout the community to insure the provision of The Center's many programs. In fiscal year 1983 a $192,470,000 budget has been successfully underwritten. A fact of which The Board is particularly proud it that all income is based upon private and corporate giving; there are no state or federal monies received into the program.

What do the solicited dollars buy? The program's most widely recognized and utilized services is its' 24-hour Crisis Line. The telephone crisis counseling program is staffed by carefully screened and highly trained paraprofessionals who volunteer their time. Training of these crisis counselors is done under the supervision of mental health professionals within the community who volunteer their time to a Clinical Advisory Board which oversees the clinical training and activities provided by The Center. Available to anyone of any age who has access to a phone, approximately 30 percent of all calls received on the Crisis Line are from adolescents. Additional services earmarked as of potential impact upon adolescent suicide are The Center's educational services. A Speaker's Bureau staffed jointly by professional staff members and volunteers provides presentations to students and teachers, often with the assistance of educational films, to identify the warning signs observable in 80–85 percent of persons who approach a suicidal crisis. These efforts were recently augmented when a unit on suicide and its prevention was added into the Health Curriculum of the Dallas Independent School District for 9–12th grade students. An additional support of the Center's school education projects comes from Dallas radio station KAAM/KAFM. This station, recognized within the community as having one of the larger adolescent audiences, asks guest artists it promotes within the community to tape public service announcements discouraging suicide and supporting a healthy awareness of the problems of adolescent suicide and what can be done about them. Additionally, the station provides disc jockeys who are familiar to local youth to assist The Center's staff in school assemblies.

Recognizing the positive influence adults can have upon the experiences of young people, The Center also provides educational programs, again of a prevention nature, to parents' groups, teachers' inservice programs, pastors' groups, area professional schools (nursing, social work, psychology, medicine, theology), professional counselors' groups, and law enforcement personnel. Workshops are annually pre-

sented to parents and teachers regarding stress management, crisis intervention techniques, and promotion of physical and emotional well-being. A program which has been particularly well-received, The Adolescent Symposia, is a collection of seminars and lectures which span several months. Health care professionals from throughout the United States are brought into the Dallas area to provide local health care professionals, who address the problems of adolescents on a daily basis, with current information and experiences which may prove helpful in decreasing the multiple dilemmas facing our young people. Again, the program's success is enhanced by the financial support and technical assistance provided by groups outside The Center, in this case Dallas' Letot Center and The Junior League.

Further services which provide support to individuals who experience suicidal feelings include The Center's Outreach Program which provides face-to-face crisis counseling to individuals for whom traditional telephone crisis counseling is deemed of questionable immediate benefit. A pair of crisis counselors, comprised of one carefully screened and trained volunteer crisis counselor and one professional staff member, meet with the distressed individual in a pre-arranged, neutral location to assist the person through the crisis period. Referral to services within the community which may provide further assistance often results. Persons who have made one or more suicide attempts are eligible for participation in The Center's Suicide Attempter's Group, presently unavailable by The Center for teens. The group is conducted by a volunteer mental health professional from within the community and a member of the professional staff. The focus for the group has remained upon providing these individuals with much needed emotional support, encouragement, and development of personal goals which facilitate adaptive, resilient approaches to problem-solving. An additional community service is provided to persons experiencing grief following the suicide of a friend or relative. The Center's survivors of suicide program establishes a supportive environment in which an eight-week grief resolution series is presented. During the series, family members or close friends of the suicide victim are encouraged to identify and express the myriad of feelings which follow a suicidal death. Additionally, techniques for coping with grief and developing a plan for resolving grief are highlighted.

Programs which are identified as priorities for the Dallas Suicide and Crisis Center await only the community support necessary to fund these additions to The Centers's services. Recent suicides in the community of Plano, Texas, rapidly growing city less than twenty miles north of Dallas, produced an environment in which crisis intervention services to many of the youth and parents of the community evolved. Support programs for managing the intense grief experienced by those surviving the suicide of a friend or relative were provided in settings as varied as schools, churches, and individual homes. These Survivors of Suicide groups, as well as intensified Speakers' Bureau activity, were well-received within a community known for tackling its problems directly and quickly and underscored the need for additional services designed to address the specific crisis intervention needs of the young people themselves.

The Dallas Suicide and Crisis Center believes the funds will come, as they have in the past, when the community's awareness of the needs for expanded teen services is increased. As the awareness increases and funds become available, The Center plans to add to its staff a Youth Services Director who will be charged with establishing liaison services within the school systems and community agencies serving youth. Survivors of Suicide groups for young people who have lost a friend or relative to suicide will surface in order to help them learn to express and manage feelings of grief. Support groups, identified as Suicide Attempter's Groups, for youth with a history of one or more suicide attempts will provide therapeutic aid to youngsters desiring to add new coping skills into their lives. A Teenage Hotline, staffed by carefully screened and trained young people, will provide telephone crisis counseling services on a teen-to-teen basis. Too, peer counseling programs utilizing a "buddy system" of providing support during a crisis are being explored.

The future of our young people is not only reliant upon the educational and experiential opportunities afforded them by adults, but also contingent upon our ability to provide them with skills which enhance adaptability and resilience and creative problem-solving. It is contingent upon conveying to them a sense of a positive future in which physical and emotional and spiritual well-being is not a theoretical concept but a meaningful lifestyle. It is contingent upon a sense of growing personal freedom and power which invites them to want to live—contingent upon there being a reason for living which surpasses a desire to die.

The volunteer Crisis Counselors, who remain anonymous to protect their personal privacy, staff, and Board-level volunteers of the Suicide and Crisis Center of Dallas, Texas extend their greetings and appreciation to members of the House Select Com-

mittee on Children, Youth and Family for their timely consideration of this growing waste of our human resources—adolescent suicide. We hope the awareness which will be elicited from your deliberations will bring about positive solutions throughout our nation.